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ABSTRACT

Comprehensive mental health programs should be designed on the basis of identified mental health needs and locally established priorities so that the resulting combination of services is geared to the specific and unique requirements of the catchment area. In addition to being comprehensive, local programs should be physically accessible, ensure continuity of care, and pursue nondiscriminatory admissions and treatment policies. It also is vital that the services basic to a community mental health program function as components of the larger human services system meeting clients' other needs. No mental health service is fully effective or even relevant unless it is linked to the total caregiving system. The eight basic services discussed at length in the report are: consultation and education, emergency services, ambulatory services, day and evening treatment services, vocational rehabilitation, social rehabilitation, community residences, and hospital care and treatment. Effective administration requires that the area be responsible for planning, developing, monitoring, evaluating, and managing its own activities and resources. Area offices, therefore, must be established with the capacity to manage their own affairs. The functions can be grouped into six major categories: (1) executive, (2) clinical services administration, (3) business, (4) community participation, (5) evaluation and data systems, and (6) resource development. (Author)

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Developing Community Mental Health Programs:

A Resource Manual

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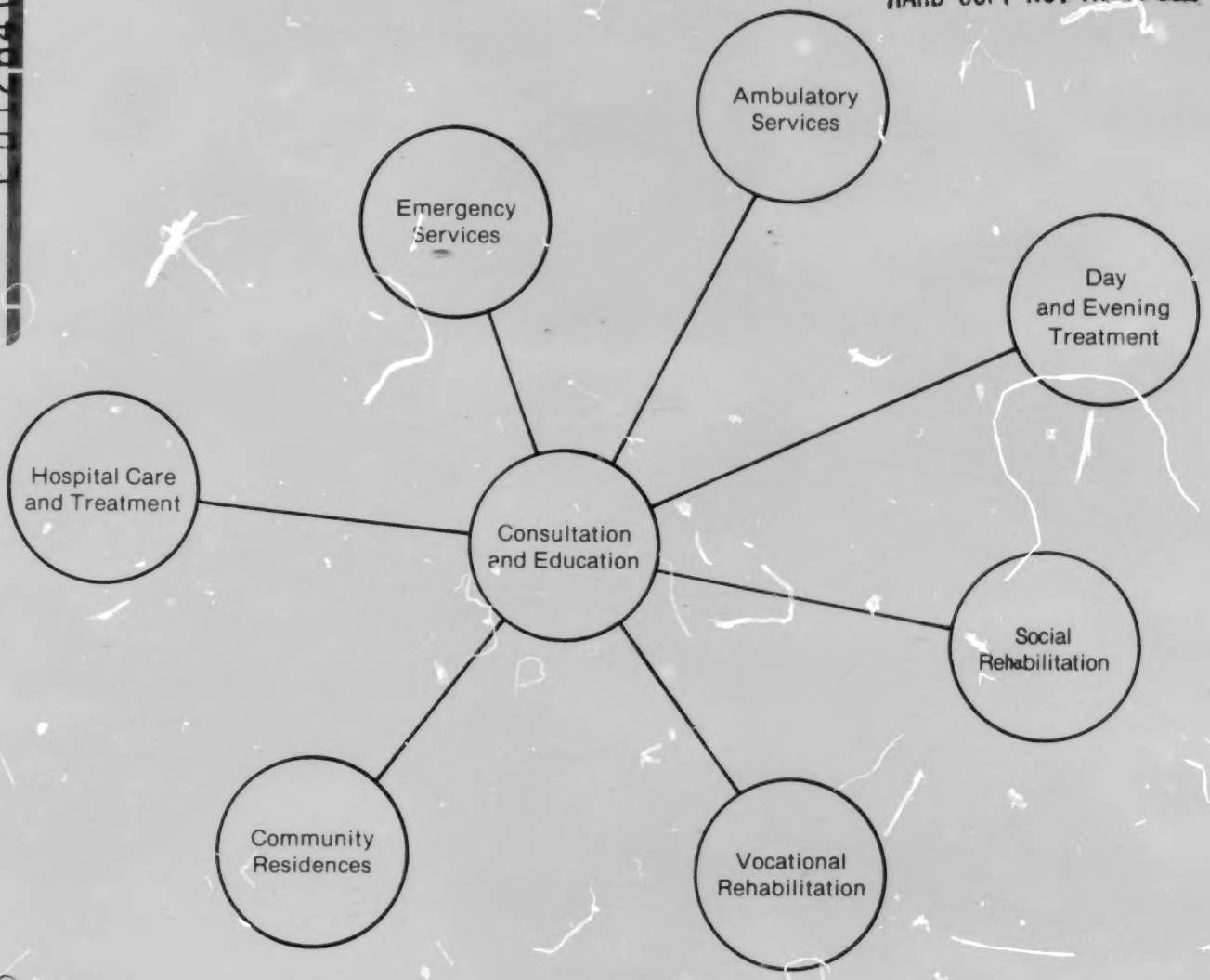

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Prepared by
Task Force on
Community Mental Health
Program Components

United Community Planning Corporation
and
Massachusetts Department of Mental Health

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May 1975

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United Community Planning Corporation is the planning partner of the United Way of Massachusetts Bay. It is a nonprofit, citizen-led, human services planning and research organization.

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May 15, 1975

Dear Colleague:

The Massachusetts Legislature passed the Community Mental Health and Retardation Act (Chapter 735) almost a decade ago. It may, therefore, seem strange now to publish a Resource Manual for use by those developing such programs. The truth, however, is that comprehensive programs still are lacking in many parts of the state. Even where they do exist, the clinical elements of basic services, organizational patterns for administering them, staffing needs, and costs and income sources often are ambiguous or confused.

The Task Force on Community Mental Health Program Components was organized in spring 1974 at the request of former Commissioner William Goldman under the initial chairmanship of Dr. Robert Cserr to assemble information about these issues. The Task Force's mandate was to analyze ways in which unresolved clinical and administrative issues affect direct and indirect care for the adult mentally ill. Similar analyses, obviously, are very much needed if services to children, the elderly, and retarded are to be improved. Such analytic efforts, however, were beyond this Task Force's scope of responsibility and should be assigned future task forces.

Administered by United Community Planning Corporation with the partial support of a 314(D) grant from the Massachusetts Department of Mental Health, the Task Force met regularly from spring 1974 to spring 1975. The thinking and recommendations of its members, both service providers and actual consumers, were particularly guided by these principles: (1) state hospital phase downs require greater emphasis on community-based services for persons previously cared for in institutions; and (2) budgetary cutbacks at the state and federal levels require that appropriated funds be used as effectively and efficiently as possible.

This Resource Manual produced by our Task Force is intended for members of Area Boards, Area Directors, and other citizens and professionals concerned with program development at the community level. The program descriptions included in the Manual are intended as examples only; they need not be emulated if deemed irrelevant to local circumstances. No single program pattern is applicable to all catchment areas, and local concerns must be considered in the planning and operating of community services.

The Manual's primary orientation is towards procedures for meeting the needs of adults through consultative, ambulatory, emergency, and other non-inpatient services. Hospital care should be provided only in those limited instances where it is essential. A correlate of this orientation is that mental health programs are part of the larger network of human services; the former can be effective only when the latter are available and accessible.

This orientation to meeting our population's mental health needs contains many implications for altered Department of Mental Health services, new staff roles, and modified administrative structures. Numerous suggestions for necessary changes are contained in the Manual—still others will occur to the reader. Program and staffing modifications consistent with the Manual's orientation already have been initiated by the Department of Mental Health, but follow-up is needed to insure their continuing implementation. We hope this Manual contributes to this process.

THE PLANNING PARTNER OF
United Way

The Task Force expresses its appreciation to former Commissioner William Goldman for his firm support of its activities during the past year. The community mental health principles and practices described in this Manual reflect much of Dr. Goldman's vision for how best to meet the needs of adult mentally ill persons. Commissioner Lee Macht, a member of the Task Force, also provided invaluable assistance in the preparation and production of this Manual. Finally, the Task Force expresses its appreciation to James Pisciotta of United Community Planning Corporation for his outstanding staff work. Mr. Pisciotta insured that our work proceeded smoothly and efficiently; he contributed to the substance of this Manual; and he directed its production.

Sincerely,

Gerald L. Klerman

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The Commonwealth of Massachusetts
Department of Mental Health

LEE B. MACHT, M. D.
COMMISSIONER

190 PORTLAND STREET BOSTON MASS 02114

TO: Department of Mental Health Personnel,
Clients and Their Families,
and All Concerned Citizens

DATE: May 15, 1975

In 1966 the General Court enacted Chapter 735 of the General Laws which restructured the Department of Mental Health and laid the groundwork for a system of area-based comprehensive community mental health care. There has been slow but steady progress toward this goal. The Department and the public policy of the Commonwealth are committed to the development, area by area, of community services linked to upgraded hospital-based services. Our goal is to provide highest quality, accessible, relevant care to all of the people of the Commonwealth. Our services must relate to citizen needs as they define them, be provided where our clients wish to enter our system and where we can best serve them, whether in the neighborhood, central mental health center facility, hospital, or as part of another community agency.

Why has it been so difficult to achieve this goal? Our problems have been budgetary, organizational, attitudinal and educational. The report which was prepared by United Community Planning Corporation and the Department of Mental Health over a year ago entitled "Community Mental Health and The Mental Hospital" described many of our dilemmas.

This Resource Manual, developed by the United Community Planning Corporation/Department of Mental Health Task Force on Community Mental Health Program Components, is a second step in the process of our evolution toward community-based care linked to hospital services. The Manual was largely written during the tenure of Commissioner William Goldman who commissioned it and who devoted considerable energies to its development. It reflects an attempt to build upon the changes which were beginning during the tenure of Commissioner Milton Greenblatt and the earlier planning which occurred during the commissionerships of Drs. Jack Ewalt and Harry Solomon.

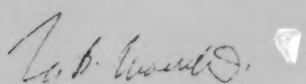
Community mental health is not new to Massachusetts and it is my distinct pleasure, as the current Commissioner, to accept and totally endorse this excellent Resource Manual. This endorsement represents the continuing commitment of the Department and the Commonwealth to this system of care. Further, it represents a recognition that a Manual such as this is essential in providing guidelines and information as we educate ourselves to continue to fulfill the mandate of Chapter 735.

The Manual should be read, studied and discussed by staff, concerned citizens, planners and students alike. It should become a cornerstone of our educational, planning and program development and operation efforts. It is a very useful attempt to assist in the implementation of our work to develop community-based services of the highest possible quality.

The Manual should be viewed in the context of organizational and budgetary changes which must occur over the next months and years including the development of a plan and its implementation statewide for a system of mental health care based in the community with the active participation of citizens.

There is no question that our efforts to maintain progress occur during a very difficult period. However, I have no question that we can maintain our momentum,

consolidate our gains, and continue our long process of constructive change. The current context highlights the need to demonstrate fiscal responsibility on all our parts. This is not inconsistent with our basic goals of quality care and community program development. We will need creative administration, imaginative planning and implementation, and enduring commitment to our goals. This Resource Manual is an integral part of those efforts and embodies these principles. We are all indebted to those whose talents and experience led to its development. The Department, Commonwealth, and I personally commend it to you, as you participate with us to make the dreams of the late fifties and sixties the concrete realities of the seventies.



Lee B. Macht, M.D.
Commissioner

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ERRATUM P. 21, Column 2

An emergency service which is part of a psychiatric facility could offer program coverage in greater depth and at less expense if the legal right (Annotated Laws of Massachusetts, Chapter 123, Section 12) to apply for another person's hospitalization (i.e. transport the person to a mental hospital for examination) is extended to nurses with Master's Degrees in Psychiatric Nursing, Social Workers with Master's Degrees of Social Work, and licensed psychologists. At present, this is legally restricted to psychiatrists and policemen.

Although the above may seem a radical suggestion, in many mental health centers it is already the current practice to provide master's-level nurses, social workers, and psychologists with "Section 12" applications presigned by a psychiatrist. It is recognized that persons thus trained are as able to judge the necessity for hospitalization assessment as psychiatrists. In the light these realities, legal recognition, and protection should be extended to the highly trained mental health personnel who are expected in the course of their jobs to transport persons for psychiatric assessment. This legal right should adhere to a specific Department of Mental Health job slot or function and would be extremely useful in rural and suburban areas.

The need to adequately protect the civil rights of persons who may become patients must receive the highest priority under existing as well as proposed procedures. Emergency service personnel, whether operating from a hospital or a nonpsychiatric service, must routinely inform both the prospective patient and any other interested parties, such as the family and friends of the prospective patient's civil rights. Moreover, all persons with the power to transport persons to hospitals for psychiatric assessment should pass a course on the civil rights of patients and then be held legally accountable for insuring that these civil rights are protected.

Summary

Almost a decade has passed since the Massachusetts Legislature in 1966 passed the Community Mental Health and Retardation Act (Chapter 735). Much has been accomplished during this period. Comprehensive mental health services are being provided in many parts of the state and emotionally disturbed persons often can obtain rapid and effective help. However, even more still remains to be done in helping the mentally ill obtain necessary care. Despite our present public policy of expanding services in each catchment area, 80 percent of state funds for mental health care is still allocated to mental hospitals. The vast majority of this money is utilized for the inpatient care of psychotic adults; only approximately 11 percent is directed towards children's services.

The 1973 Report of the Massachusetts Mental Hospital Planning Project asserted that the aims and provisions of Chapter 735 will not be achieved until: (1) program and clinical responsibility for the residents of a catchment area are shifted from the state hospital, as an institution, to an area program with its own director and (2) the resources so long controlled by the hospitals also are shifted to the area level.

What obstacles impede these shifts and continued progress towards the goal of comprehensive community mental health services? Without a doubt, administrative patterns, personnel policies, fiscal concerns, and ambivalent community attitudes are lingering impediments. We, nevertheless, must move forward in the next crucial phase of providing the full array of basic services needed within each catchment area.

Comprehensive programs should be designed upon the basis of identified mental health needs and locally established priorities so that the resulting combination of services is geared to the specific and unique requirements of the catchment area. In addition to being comprehensive, local programs should be physically accessible, insure continuity of care, and pursue nondiscriminatory admissions and treatment policies. It also is vital that the services basic to a community mental health program function as components of the larger human services system meeting clients' other needs. No mental health service is fully effective or even relevant unless it is linked to the total caregiving system.

The Eight Basic Services

As the planning of comprehensive programs proceeds within each catchment area, citizen boards and program directors should strive to insure the availability of eight basic services. For each service component, they will have to consider organizational auspices, clinical elements, staffing patterns, necessary facilities, costs, and income sources. Knowledge and sophistication about these dimensions vary considerably. Much is known about clinical and professional requirements, relatively little is known about associated costs and potential income sources. This Manual, therefore, seeks to describe contemporary expert opinion while recognizing that significant knowledge gaps still remain to be filled.

The eight basic services provided within the catchment area should be viewed as comprising a clinical continuum. Service 1 — consultation and education — is at one extreme while service 8 — hospitalization — is at the other. Consultation and education usually should be the mental health professional's initial intervention of choice. Hospitalization should be utilized only after all intermediate interventions have been exhausted.

The eight basic services are the following:

1. **Consultation and Education.** Most of the mental health professional's time is spent in providing direct services to clients, but the indirect service of consultation and education also is necessary in extending his/her efforts. Consultation and education is the provision of technical assistance by an expert to individual and agency caregivers in relation to specific mental health-related work problems. The C&E is advisory in nature, and the consultant has no direct responsibility for its acceptance and implementation.

   Consultation activities can be categorized as client or case centered, and program centered. The former focuses upon the interpersonal relationship between consultees and their clients; the latter deals with problems in planning, developing, managing, evaluating, and coordinating services affecting the community's mental health. Most mental health consultation focused inititally on client-centered issues, but in recent years increased effort has been directed towards program consultation. The precise balance of consultation and education activites should be established in relation to a mental health center's goals and priorities, the staff's expertise, the population's needs, and the range of caregivers in the community.

   Consultation and education remains a relatively underdeveloped service in most mental health centers; in Fiscal Year 1974 only five percent of an area's mental health budget was expended on this basic program component. Among the complex reasons for this situation is the reluctance of most funding sources to pay for indirect clinical care. Current arrangements between mental health clinics and public welfare offices for Medicaid reimbursement of

case consultation may be the harbinger of expanded fiscal support.

2. **Emergency Services.** American society has developed sophisticated systems for handling medical emergencies but the other psychosocial crises of daily life generally are met in haphazard ways. Comprehensive "crisis-emergency teams" have been difficult to establish since most caregiving personnel seek to clearly delimit areas of responsibility while people and their problems rarely conform to established guidelines. Various "model" emergency services now exist, and they include such diverse elements as general hospital care, mental health assessment and intervention, hotlines, and counterculture settings.

   Personnel operating an emergency service should possess the clinical skills, experiences, and language fluency appropriate to the service's clients. This is most readily insured when staff reflect the characteristics of the population as a whole in terms of sex, socio-economic background, and educational attainment.

   An emergency service which is part of a psychiatric facility could function more effectively if the legal right to admit patients for 10 days involuntary observation were extended to master's degree nurses and social workers, and licensed psychologists. The need to protect the civil rights of persons who may become patients must receive the highest priority under existing as well as proposed procedures.

3. **Ambulatory Services.** Well-established outpatient services increasingly are being termed "ambulatory" to emphasize the mobility of both staff providing services and the clients receiving them. Rather than being concentrated in central facilities, ambulatory services now emanate from local and even neighborhood sites. In fact, the optimal target population for this service may be as low as 10,000 people.

   Ambulatory care can be categorized into three major types: (1) information, screening, and referral services; (2) problem evaluation, examination, and assessment services; (3) treatment or counseling services. All three types should be delivered within a philosophy of outreach, prevention, and early identification. At the various stages of diagnosis, treatment planning, and clinical review, clients and their families should be informed of what is occurring. Differing skill levels are needed to provide these services, and several staffing trends are apparent. Most notably, highly trained professionals are assuming increased consultative responsibilities while paraprofessionals and volunteers are being used as therapists.

   State-sponsored clinics and mental health centers traditionally provided the largest volume of ambulatory service. More recently, the growth of third-party payment mechanisms has generated increased services among private nonprofit as well as proprietary organizations, and clients in many parts of the state can now choose among diverse resources. Existing models of ambulatory care also differ in accordance with the catchment area's urban, suburban, or rural nature.

4. **Day and Evening Treatment Services.** It is clear that when properly organized and linked to other human services, day and evening treatment is equal to, or superior to, acute psychiatric hospitalization for a broad cross-section of disturbed persons needing intensive care (Level I). Day and evening treatment also is essential in caring for clients requiring longer term treatment and rehabilitation (Level II). After being significantly underutilized for many years, day and evening treatment has been among the fastest growing service elements in expanding community programs.

   The size of a day and evening center will vary in accordance with the catchment area's population, density and transportation patterns, the minimum to maximum number of persons served by a program unit can range from 10 to 70 enrollees. Treatment programs should include resocialization and rehabilitation activities, preferably based in a "therapeutic community" format which permits individuals to attain their own maximum levels.

   The staff of a day and evening treatment center must have the interests, abilities, and motivation to function in an innovative setting. Experience has shown that many personnel without formal graduate training are highly skillful in assisting patients. Staffing patterns should vary with the intensity of treatment services; Level II programs, therefore, should not require that all staff have extensive formal mental health training.

5. **Vocational Rehabilitation.** An emotionally disturbed person's need to maintain employment has not received adequate attention from mental health and rehabilitation programs despite our society's emphasis upon productivity and self-support. Both federal and state legislation now recognize vocational rehabilitation of the severely disabled as a priority; and new opportunities, thus, exist for the Massachusetts Department of Mental Health and the Massachusetts Rehabilitation Commission to work cooperatively.

   Depending on the person's needs, vocational rehabilitation including evaluation and counsel-

ing may be a brief or extended process. Changes in work placement should reflect the person's capacity, with the rehabilitation process resulting in a gradual increase in functioning and maximizing of potential. Work performed by psychiatric patients need not be only in the competitive work force; persons unable to perform at this level can be provided meaningful and successful experiences in sheltered settings.

The effectiveness of vocational rehabilitation can be furthered by appointing a community rehabilitation coordinator in each catchment area. The coordinator would be responsible for overseeing not only vocational rehabilitation activities but also community residences and socialization and recreational programs. The organization of an area's vocational rehabilitation workers into teams provides another effective vehicle for implementing local programs.

6. **Social Rehabilitation.** Many mentally ill persons need assistance in learning to cope and adjust within social situations. Rehabilitation services emphasizing the development of social skills are essential. They may be offered as a component of larger programs, or they may be provided as a free-standing service.

   Social rehabilitation services generally include some or all of these elements: remotivation, resocialization, skills of daily living, and recreation. Appropriate settings for providing these services include social clubs, common interest groups, and psycho-social rehabilitation centers. All of these settings permit the mentally ill to seek meaningful community support through peer group assistance.

   The staffing of social rehabilitation programs should include a broad range of skills, with less concern for specialization than may be the case with regard to clinical services. Particularly valuable are individuals with broad backgrounds who can provide several types of service once trained.

7. **Community Residences.** Clinicians have become increasingly sophisticated in minimizing long-term inpatient care, and it is evident that several groups of patients can be maintained successfully in community residences. These people range from those who in crisis require short-term, intensive nonmedical supervision and support to those who after long periods of hospitalization are capable of personal care but lack social skills and competencies. In response to the differing needs of each of these groups, several types of community residences have evolved which include group residences, halfway houses, cooperative apartments, and foster families. Residents accept varying degrees of responsibility in each setting.

   Each community residence must insure a variety of services, not just physical shelter, to assist residents in managing their mental health as well as basic socio-recreational needs. These services include intake/screening, goal development, daily programs, recreation, and professional psychiatric, medical, dental, and rehabilitation care. Residents should be encouraged to utilize local community resources as would any other citizen in the community; providing all services within the residence itself is akin to institutional programming and should be discouraged.

8. **Hospital Care and Treatment.** A key goal of community mental health programs is to reduce hospitalization and to shorten its duration when required. Once an area has developed a comprehensive resource network, it should be able to handle many and perhaps even all persons now admitted to hospitals. Since hospital care is the most costly of all services, its use should be limited to circumstances where: medical diagnostic and treatment facilities are needed; security of the client and/or the community requires 24-hour care; treatment can be controlled only in a hospital setting; and no other facility is appropriate for around-the-clock observation. Area program staff should consider hospital care as being potentially needed by the adult mentally ill, both those currently residing in state hospitals and those acutely disturbed; aggressive and potentially violent male and female patients; legal offenders; children; developmentally disabled persons; adolescents; the elderly; alcoholics; and drug dependent persons. With all of these groups, inpatient care should be the major treatment of choice only under the previously mentioned circumstances.

   Inpatient services can be provided in unitized programs of state hospitals, community mental health centers, private psychiatric hospitals, and in psychiatric units of general hospitals. Clinicians should design treatment plans so that the patient and members of his/her social network take responsibility when possible for defining the problem and changing troublesome relationships. Thus, the social and physical environment in which a person is treated is, in itself, a key factor in treatment success.

Area Program Administration

Effective administration of a comprehensive area program providing the eight basic services requires that the area be responsible for planning, developing, monitoring, evaluating, and managing its own

activities and resources. Area offices, therefore, must be established with the capacity to manage their own affairs. The functions performed by an area office can be grouped into six major categories: (1) executive, (2) clinical services administration, (3) business, (4) community participation, (5) evaluation and data systems, and (6) resource development.

Staffing patterns for area offices must be adequate to implement these six major functions. Since the major thrust of area programming is toward decentralization and tailoring of structures to unique area needs, it is best not to delineate a single staffing pattern relevant to all existing and future programs. Administrative needs necessarily differ from program to program. Nevertheless, in all instances the staffing of an area office should include an Area Director assigned overall responsibility, and other personnel with the clinical competence and technical expertise to administer sizable budgets.

Area administration should be funded in relation to the size of an area's program budget, approximating seven to eight percent of the total funds in areas with very large budgets and 10 percent or more in areas with small budgets. Administrative resources from phased-down state hospitals as well as from the Department of Mental Health's Central Office could be reallocated to achieve area-level managerial capability.

Expanded administrative structures at the area level should not merely be another added layer of bureaucracy. Instead, as community programs expand and appropriate functions and resources of institutions are transferred to them, the related functions and resources of the regional offices and the Central Office should similarly be transferred to area-level administrators.

The goal of administrative flexibility and program creativity at the area level requires that the Legislature forego its practice of exercising line item fiscal control over mental health budgets. Administrators incapable of managing programs within prescribed standards of responsibility and accountability should be relieved of their duties; constraining them by excessive controls is an inappropriate solution.

Implementing Community Mental Health Programs

Each of the eight services integral to a catchment area's comprehensive program has unique clinical characteristics, staffing requirements, cost considerations, etc. However, these services also are closely linked and interdependent and when viewed collectively, certain trends and program directions become quite evident. An awareness of these trends and directions helps in coping with the forces facilitating or impeding the achievement of locally established program goals.

Organizational Auspices. The Department of Mental Health has been the major service provider in Massachusetts, and it has established many innovative and pioneering programs. However, publicly operated programs are subject to many governmental constraints; and the alternative of contracts with voluntary and private agencies is now receiving increased attention. Contracting has many well-known advantages such as budgetary control and flexibility. Perhaps most significant in times of fiscal austerity is that nonpublic agencies can bill third-party sources and retain the receipts for direct use in mental health programs. Third-party payments obtained by the Department of Mental Health revert to the Commonwealth's General Fund. In order to achieve maximum benefit from varied funding sources, Area Boards should decide which program components can best be contracted, which should be provided through Department of Mental Health staff, and which in combination.

Program Components. Community mental health programs are shifting away from the predominant emphasis now placed upon hospital care and are utilizing ambulatory services to a far greater extent. These alternative interventions better meet client needs during crises, they reduce dependency, and they are more economic.

In planning comprehensive area programs, administrators should consider how best to distribute the more than 70 clinical, administrative, and support functions integral to these programs. Some system functions such as recordkeeping must be performed by all of the basic services; other system functions such as the dispensing and supervising of medication are performed best by some services but not by others.

Recent progress in expanding community mental health programs will not be sustained unless ever-emerging problems are resolved. Those problems looming most prominently are: local opposition and resistance to neighborhood residences; concern about potentially adverse economic effects in locales where state hospitals are phased down; and fear of labor unions and professional groups about job security for their members when personnel are redeployed from state hospitals to community-based programs.

Clients and Their Families. Mentally ill persons are highly vulnerable to the whims and dictates of caregivers, and safeguards must be established to insure that even well-intentioned but destructive actions are not directed against them. The "civil rights officer" approach thus far has been of limited effectiveness in Department of Mental Health facilities, but possibly can be made to work with more staff. Perhaps the best safeguard against abusing the

mentally ill is to have them and their families actively participate in treatment planning and decision-making. They not only have a right to do so, it is good treatment practice as well.

Staffing. Providing the full range of community mental health services within each catchment area will require shifts in staff utilization patterns. For example, in Fiscal Year 1974, 67 percent of an area's mental health budget was allocated for the staffing of adult inpatient services. Given present fiscal stringencies, some of these resources must be shifted if clinical alternatives to hospitalization are to flourish. Since personnel reallocations inevitably create anxiety about job security, staff reassignments must proceed in carefully delineated ways.

Community mental health programs have offered expanded job opportunities for white male professionals, but women and minority group members have benefited less. The administrative principle should be that of having a staff which reflects the composition of the population being served. Also to be considered in this regard are former psychiatric patients and volunteers, two groups possessing relevant skills but underrepresented in present staffing patterns.

Costs and Income Sources. Few, if any, comprehensive mental health programs exist as yet in Massachusetts so that only tentative projections can be made about their costs. Area mental health budgets averaged approximately $2 million in Fiscal Year 1974, and costs will grow with program expansion and inflation. The delivery of services through community-based facilities, thus, should not be viewed as generating fiscal savings. Instead, this delivery system is intended to increase efficiency and effectiveness by providing timely care which reduces a patient's subsequent dependency and debilitation.

Funds necessary to support comprehensive programs may be sought from a combination of sources including the federal, state, and local governments, and third-party reimbursements. The present major third-party sources include Medicare, Medicaid, Title XX of the Social Security Act, CHAMPUS, Federal Employee Health Benefit Program, and private and commercial insurers. Psychiatric benefits will become available January 1, 1976 to all medical and surgical insurance policyholders in Massachusetts, and this change will significantly increase revenues from private and commercial insurers.

Section I. Into the Community: Problems and Progress

Reform of the system whereby care is provided the mentally ill has been going on ever since people and their governments decided to help emotionally disturbed persons. The current wave of reform intensified after World War II. Particular concern was directed to the quality of care provided in the public mental health system, and these concerns led to passage of the 1963 Federal Community Mental Health Centers Act. The federal legislation provided funds to help states develop comprehensive plans incorporating the community mental health concept, it appropriated $150 million to the National Institute of Mental Health for construction and staffing of centers during Fiscal Years 1965-1970, and it led to defining the functions of a community mental health center.

The Massachusetts Mental Health Planning Project was established in 1963 with the support of federal planning funds to review the service needs of Massachusetts citizens and to recommend the structures required to establish comprehensive state programs. The Project's 1965 recommendations became the basis for Chapter 735, the Massachusetts Comprehensive Mental Health and Mental Retardation Services Act passed in 1966. This statute produced the following actions:

1. The state was divided into 37 catchment areas grouped into seven regions;
2. The Area Board mechanism was established for citizen participation in local program planning and policy-making; and
3. A decentralized, community-based service delivery system was initiated for children and adults. The Department of Mental Health was to provide within each area a comprehensive range of services, including inpatient and outpatient services, 24-hour emergency services, partial hospitalization, and consultation and education.

Many steps have been taken since 1966 toward achieving the goals of Chapter 735. In 1969, the state hospitals were directed to unitize geographically so as to align plans and services with the catchment areas they serve. Community mental health programs have been funded by both the Commonwealth and the National Institute of Mental Health and a wide network of community-based services are in various stages of operation and planning.

Action has not kept full pace with intentions, however. Despite the stated goal of expanded community mental health care in Massachusetts, an analysis of the Department of Mental Health's operating budgets between 1962 and 1972 revealed that the vast majority of public resources were still allocated to the state hospitals for inpatient care of psychotic adults. Table 1-1 shows that the state hospitals' Fiscal Year 1974 expenditures of $93 million still consumed approximately 80 percent of state mental health funds (excluding retardation programs). Furthermore, estimates prepared by the Department of Mental Health indicate that $73 million of the $89 million available for mental health services in Fiscal Year 1974 were allocated for inpatient care of adults.[1] Services provided children in Fiscal Year 1974 through all Department of Mental Health programs (excluding retardation facilities) comprised only 11 percent of the mental health budget.[2]

In recent years, the term "deinstitutionalization" has become a nationwide symbol for attempts to fulfill the intent of Community Mental Health Acts. The term incorporates four main goals of the reform movement:

1. Mental health services should be located in local settings rather than in large institutions distant from the geographic areas being served;
2. Extensive use of inpatient services should be reduced and ambulatory care expanded;
3. The populations served should be broadened; and
4. Dependency in patients should be minimized by developing comprehensive programs which help to prevent a "revolving door" approach to care.

In recognition of the need to generate new momentum for the continued development of community mental health programs, the Massachusetts Mental Hospital Planning Project was established in 1972 as a joint citizen and professional endeavor under the sponsorship of United Community Planning Corporation (formerly United Community Services of Metropolitan Boston) and the Massachusetts Department of Mental Health. The Project's final report, "Community Mental Health and the Mental Hospital,"[3] was released in February 1974, and it stated that the aims and provisions of Chapter 735

[1] Data assembled by Mark McGrath, Special Executive Assistant to the Commissioner, Department of Mental Health.

[2] Data assembled by Dr. Mary Jane England, Director of Planning and Manpower for Children's Services, Department of Mental Health.

[3] Copies of this report are available at $2.00 each from United Community Planning Corporation, 14 Somerset Street, Boston, Massachusetts 02108.

Table 1-1. Department of Mental Health Fiscal Year 1974 Expenditures
Mental Health Services[1, 2]

State Hospitals	Expenditures	Personnel Costs 01-02 Accounts	Support Costs 03-16 Accounts
Northampton	$ 9,225,060	$ 7,433,253	$ 1,791,807
Grafton	3,228,435	2,871,330	357,105
Gardner	5,302,130	4,449,997	852,133
Worcester	10,286,279	8,610,882	1,675,397
Metropolitan	8,733,724	7,208,823	1,524,901
Danvers	8,767,769	7,036,360	1,731,409
Medfield	6,904,435	5,602,609	1,301,826
Westborough	8,295,654	7,012,477	1,283,177
Boston State	12,236,588	10,032,963	2,203,625
Foxborough	5,795,697	4,770,815	1,024,882
Taunton	8,128,824	7,026,862	1,101,962
Cushing	6,210,380	5,120,216	1,090,164
Subtotals	$ 93,114,975	$77,176,587	$15,938,388
Community Mental Health Centers			
Gardner-Athol	$ 44,947	$ 39,947	$ 5,000
Blackstone Valley	———	———	———
Solomon	1,519,405	1,282,302	237,103
Cambridge-Somerville	638,353	539,083	99,270
Waltham Hospital	112,857	———	112,857
Massachusetts Mental Health	3,785,664	3,306,999	478,665
Fuller	863,480	277,310	586,170
Lindemann	2,230,279	1,755,681	474,598
Brockton Multi-Service	20,692	———	20,692
Corrigan	1,218,339	1,045,428	172,911
Subtotals	$ 10,434,016	$ 8,246,750	$ 2,187,266
Community Services (5x21 Account)			
Region I	$ 986,446	$ 932,121	$ 54,325
Region II	1,092,245	931,456	160,789
Region III	1,672,540	1,381,090	291,450
Region IV	1,430,131	963,627	466,504
Region V	1,750,350	1,672,200	78,150
Region VI	1,881,981	1,853,298	28,683
Region VII	785,427	761,232	24,195
Subtotals	$ 9,599,120	$ 8,495,024	$ 1,104,096
Drug Rehabilitation Services			
Subtotals	$ 3,389,599	$ 379,894	$ 3,009,705
TOTALS	$116,537,710	$94,298,255	$22,239,455

[1] Prepared by Walter Sowyrda, Director of Budget, Massachusetts Department of Mental Health.

[2] Expenditures for mental retardation facilities and services are not included.

will not be achieved fully until: (1) program and clinical responsibility for residents of a catchment area are shifted from the state hospital, as an institution, to an area program under the direction of an Area Director and (2) the resources, so long controlled by the hospitals, also are shifted to the area level.

The Project's report emphasized that over the next several years new program balances must be established. The vast resources now directed toward institutional inpatient care for adult psychotics must be redeployed toward community services for not only this group but for children, the elderly, alcoholics, and others as well.

Obstacles to Continued Progress

Now that the goals of Chapter 735 have been reaffirmed and steps necessary for their implementation identified, what obstacles remain in the way of continued progress? Without a doubt, administrative patterns, fiscal and economic concerns, staff resistances, and ambivalent community attitudes are lingering impediments.

The Department of Mental Health itself, by administering a dual system of community and institutional services, has mitigated against a unified approach to meeting client needs. This dual system has been perpetuated by the Legislature through its delay in authorizing area program accounts and by continuing institutional accounts as the major Department of Mental Health funding vehicle. Currently, legislative appropriations are locked primarily into institutional or, at best, regional accounts. No true area or regional program accounts have yet been established by the Legislature. Appropriations made directly to an institution negate both the concept and substance of an areawide program in the eyes of citizens and professionals and lead people to continue viewing clinical services as primarily those provided by large institutional facilities.

Although legislative support is still evolving, the Department of Mental Health is moving toward area program responsibility by creating de facto regional and area budgeting procedures. Area-based budgets for Fiscal Year 1976 have been prepared throughout the state under the guidance of the Department of Mental Health's Central Office. The Executive Office of Administration and Finance is considering creating an "area activity" account along with an "institutional activity" account. However, if the area-centered approach is to be truly viable, it must be acknowledged and accepted in the legislative budgetary process so that these programs finally gain fiscal legitimacy.

Current rigidities in the expenditure of appropriations also make creation of relevant area programs more difficult. The inability to transfer funds between subsidiary accounts and the difficulty of obtaining services through contract are but two of the fiscal inflexibilities that make area programming, which by its very nature must bend with changing community needs and priorities, frustrating and cumbersome.

Present state Civil Service and personnel policies represent a further obstacle to area programming. Job titles, qualifications, and job descriptions for present Department of Mental Health positions were initially created and assigned to staff the large institutions. However, many of these job titles and descriptions do not fit the personnel needed to operate contemporary community-based programs; the qualifications are unnecessarily rigid and inappropriate. The problem of anachronistic personnel practices and policies is accentuated and made even more profound by necessary commitments to current state employees. There are thousands of people working in state facilities whose positions and functions are not relevant to or needed by the community programs replacing state hospital services. Current state employees must be retrained and reassigned before real deinstitutionalization and staffing of community programs will be possible.

The large scale phasing down of the state hospitals as major mental health care facilities also is feared by some to have a deleterious impact on the economy. The towns in which hospitals are located as well as surrounding towns often are viewed as dependent on the institutions for economic viability since they buy heating oil, food, supplies, and other goods which contribute to the local economy. Capital outlays by the state for construction and/or renovation of state hospital facilities also provide jobs and money for the state's construction industry.

Another category of obstacles to deinstitutionalization and community-based care is the possibility of community "backlash." Some citizens are afraid to have former patients in their cities and towns. Frequently used terms such as "inmates loose in the community" reflect this anxiety. When considered objectively, citizens may view institutionalization as less therapeutic or perhaps even inhumane in comparison to short-term treatment outside the state hospital setting. However, many citizens also view state hospitals as safe and secure isolated environments that shield them from patients as well as secure places which "protect" the patients. Only through much more careful community planning and education can fears be alleviated and the real dangers minimized.

One last obstacle worth noting is the ambiguity of the law regarding powers invested in the Area Boards. Although these citizen groups are designated by law as "advisory" bodies, the law has given the Boards implied powers around the budget process. Furthermore, the Area Boards have been promised more and more informal de facto authori-

ty in fiscal, personnel, and program development through statements of Department of Mental Health officials even though the law itself does not make such provisions. Some clarification of this ambiguity is urgent to avoid a future impasse between Area Boards, Area Directors, and the Commissioner.

Immediate Prospects

Despite these remaining obstacles, many promising steps are being taken by the Department of Mental Health towards deinstitutionalization and area-based mental health services. These include the funding of Area Director positions and selection of persons to fill them, the beginning reallocation of positions from state hospitals to community programs, a project to update the personnel classification system, pending legislation to create regional instead of facility budget accounts, and efforts on the part of former Commissioner Goldman and his staff to clarify functional responsibility on the regional and area levels.

It is clear that the crucial next phase of the movement toward community care is completion by the Department of Mental Health of its mandate to provide in each catchment area the full range of essential services. This Manual is a guide for Area Boards and professional staffs in the 39 areas in developing long-term plans for comprehensive programs. It should be emphasized that this Manual's primary focus is upon services for the adult mentally ill. Although much of the program approach described in the following sections can in many ways also be generalized to such populations as children, the elderly, and retarded, resource manuals focusing upon the specific program needs of these latter groups also should be produced by the Department of Mental Health.

If community mental health programs are to be effective, they must be designed to meet the area's unique needs. In order to accomplish this, responsibility and resources must be under the direction of the Area Director in conjunction with the Area Board. Program planning for the optimal use of resources should include the following processes:

- Identification of needs;
- Survey of resources available to the area;
- Setting of area priorities;
- Reallocation of current resources, and seeking new resources such as money, space, personnel and authority; and
- Ongoing monitoring and evaluation to allow for flexible change.

If these processes are included in each area's program design, the result likely will be a combination of services geared to the specific mental health needs of the local population. The following sections of this Manual detail the manner in which each of the basic services may be planned and delivered on an area basis.

Section II. Community Mental Health Program Components

The 1966 Massachusetts Comprehensive Mental Health and Retardation Services Act (Chapter 735) introduced community mental health concepts into what previously had been a nonsystem of scarce and circumscribed services. The legislation required that publicly supported mental health services be strengthened and reorganized to achieve the following client-oriented objectives:

1. Comprehensiveness—A wide range of services is needed so as to be responsive to varying client needs;
2. Accessibility—Services should be located within relatively easy traveling distance for every client who needs them;
3. Continuity of Care—An ongoing client-caregiver relationship should facilitate client movement from one service element to another as client needs change; and
4. Equity of Access—There should be a nondiscriminatory admissions and treatment policy; no client should be excluded from receiving services on the grounds of age, sex, race, religion, type of diagnosis, severity of illness, or economic status.

Section I of this Manual briefly reviewed progress and obstacles to achieving these goals. Section II focuses upon the following eight services to be provided in each catchment area: consultation and education, emergency services, ambulatory services, day and evening treatment, vocational rehabilitation, social rehabilitation, community residences, and hospital care and treatment. Procedures for determining an area's degree of need for each of these services are described elsewhere.[1]

This Manual analyzes the eight services of a comprehensive program within the following framework: organizational auspices, program components, staffing patterns, facilities, costs, and income sources. Knowledge and sophistication about these dimensions vary considerably. Administrators and clinicians have considerable expertise regarding the professional services they wish offered; on the other hand, relatively little is known about associated costs and potential income sources. This Manual should be viewed, therefore, as reflecting expert opinion as it exists in the mid-1970s, with even the "experts" recognizing that significant knowledge gaps remain to be filled.

Before detailing each of the eight services basic to a community mental health program, it must be emphasized that each service can be implemented only as a component within a complex interacting human services system. No service component is fully effective or even relevant unless it is linked to the total program. The movement of information, clients, and resources among service components is vital in creating the flexibility needed to match problems with interventions.

Continuity of Client Care

Accepting the premise that a client's needs can only be met by a comprehensive human services system, increased attention must be paid to administrative arrangements for ensuring continuity of client care. Continuity of care may be defined as operational[2] to the extent that:

1. There are no obstacles to a client remaining in or moving among direct treatment services in conformity with therapeutic needs and
2. Administrative mechanisms relate past and present care by providing:
   - Stable client-caregiver relationships;
   - Necessary communication, written and verbal, among caregivers and clients about the treatment program; and
   - Contact with clients who appear to be prematurely dropping out of treatment.

Continuity of care necessitates ready transferability of staff, records, and clients as indicated by the latter's clinical needs. It also requires a monitoring system and a plan for safeguarding the privacy rights of clients.

In a comprehensive mental health program, it is likely that clients will seek care through any of several points of entre, e.g. emergency units, outpatient clinics, etc. All such intake points are legitimate ones and once a client is accepted, he/she should be able to move freely among the available services with minimum effort. There should be the corresponding opportunity to leave the comprehensive program through a number of service "exits," but only after a method for follow-up (or aftercare) has been determined and agreed to by the client.

The movement of clients into, thhrough, and out of the human services system can be portrayed

[1] W. Hargreaves, *et al.* Resource materials for community mental health program evaluation. Part II. Needs assessment and planning. San Francisco. National Institute of Mental Health. 1974.

[2] National Institute of Mental Health. A Method for Measuring Continuity of Care in a Community Mental Health Center. Department of Health, Education, and Welfare Publication No. (HSM) 71-9067. 1972. P. 8.

through a multitude of schemes. For purposes of illustration, Figures 2-1, 2-2, and 2-3 depict the manner in which continuity of direct patient services is arranged in differing types of mental health centers.[1] Figure 2-1 is based upon a center in which all services are provided at a single location; Figure 2-2 illustrates client flow among services which are dispersed organizationally, i.e. through affiliation agreements; and Figure 2-3 delineates client flow in a comprehensive program that is geographically decentralized.

Although continuity of care can be depicted schematically with relative ease and necessary interservice agreements negotiated, in practice it is all too easy for clients to be ignored or "fall through the cracks." In response to this problem, it is suggested that each client entering the mental health system be assigned to a staff member who assumes a series of roles including therapist and case manager in accordance with the client's needs. This staff person would be responsible for insuring that clients are actively involved in appropriate services.

Another way of dealing with service breakdowns is to develop the role of ombudsman within the Department of Mental Health. The ombudsman would be assigned considerable authority to see that service inadequacies are corrected and that service breakdowns, when they do occur, are alleviated. This advocacy role also could be assigned to the Executive Office of Human Services which would deploy such persons in key locations throughout the state so that they may be highly visible to the general public. In the latter arrangement, the ombudsman would serve an advocacy function for clients served by all agencies within the Office of Human Services.

Service Delivery in Neighborhood Settings

The previously described organizational models for insuring continuity of care are based upon existing community mental health centers. A growing number of practitioners are concerned, however, that these models are inadequate since community mental health centers often do not focus on natural population groupings or on the geographic neighborhoods where people live. The poor and minority groups frequently view large community mental health centers as distant, alien, and irrelevant to their need for psychological support and material assistance. This perception is probably less true

Figure 2-1. The Center

An "Under One Roof" Approach To Direct Patient Services[2]

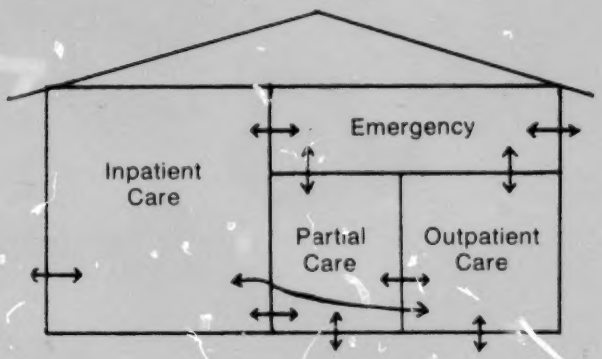
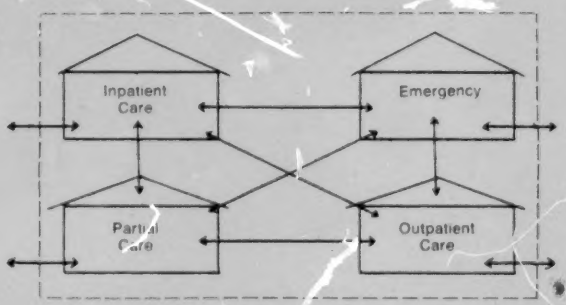


Figure 2-2. The Center

An "Under Several Roofs" Approach To Direct Patient Services[3]



where the poor participate in the mental health center; it is probably least true when the mental health center operates decentralized facilities which are part of the psycho-social matrices of the neighborhoods where people live.

In the experience of some practitioners, low-income consumers frequently feel that health services or other neighborhood-based human services are most relevant and accessible. Consumers, thus, enter more readily into a helping relationship through a neighborhood facility offering health,

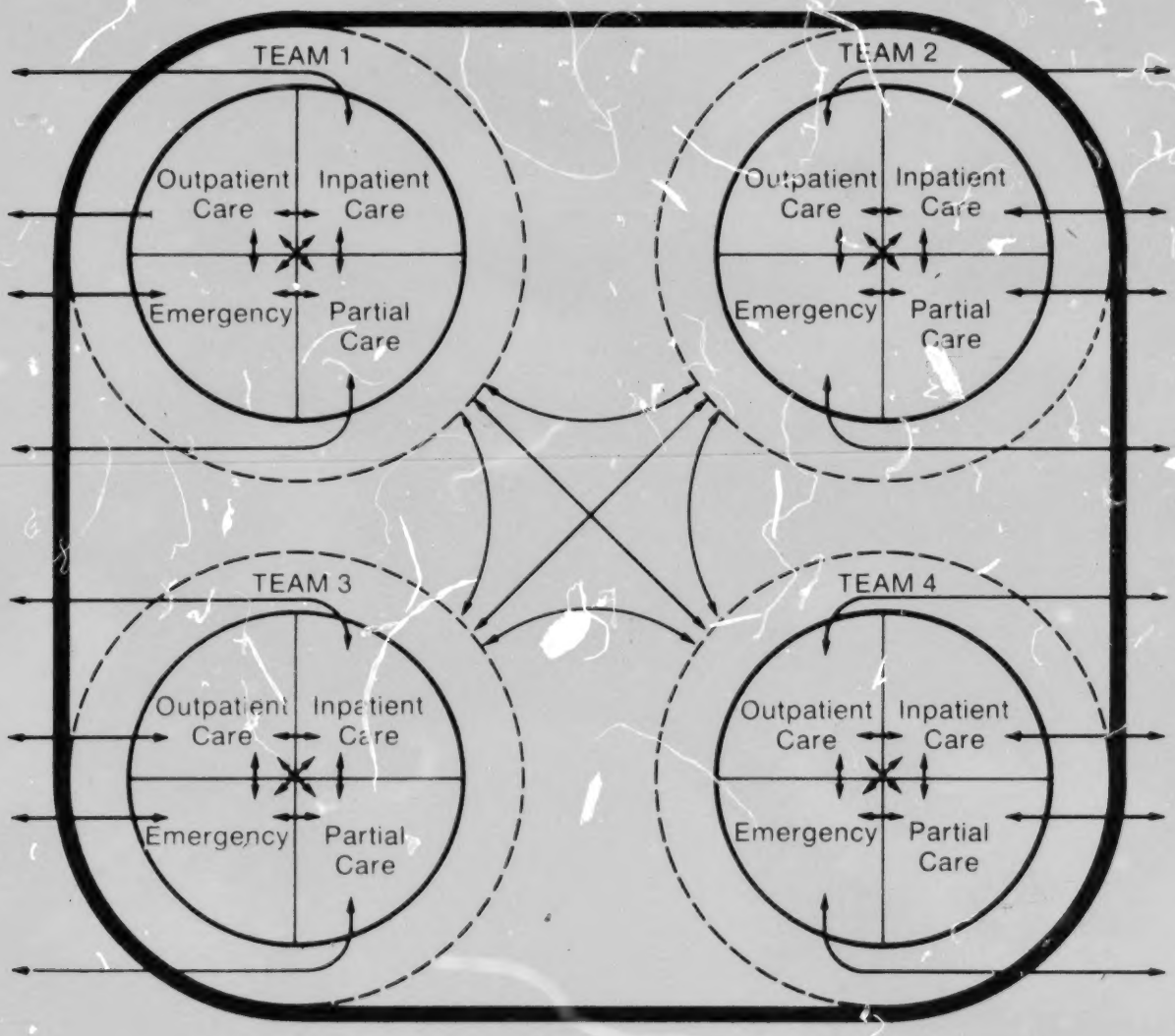
[1] National Institute of Mental Health. A Statistical Information System for Community Mental Health Centers. U.S. Public Health Service Publication No. 1863. 1969. pp. 4-5.

[2] National Institute of Mental Health. A Statistical Information System for Community Mental Health Centers. U.S. Public Health Service Publication No. 1863. 1969. P. 4.

[3] *Ibid.*, p. 4.

Figure 2-3. The Center

A Four-Team Approach to
Direct Patient Services[1]



vocational, educational or legal services. If these services are coordinated and integrated at the neighborhood level, clients can obtain more than one service when necessary and move freely between appropriate human services agencies.

In designing new organizational models for insuring comprehensive care, program directors should consider that neighborhood services offer the following advantages:

- Many low-income persons experience multiple difficulties in various areas of their life space. The neighborhood, thus, becomes a useful social unit within which to ameliorate these problems.
- The neighborhood is a manageable, geographic

[1] National Institute of Mental Health. A Statistical Information System for Community Mental Health Centers. U.S. Public Health Service Publication No. 1863. 1969. P. 5.

division whose ecologic and interpersonal forces affecting health and mental health can be understood. This allows for preventive programming and/or experimenting with new treatment ideas.
- A neighborhood center with real citizen participation is perceived as part of the community, owned by the residents, and "working for them."
- Clients often view mental health services integrated with other health services as more relevant. The services can be delivered by general health staff with mental health consultation and backup.

For the mental health practitioner, neighborhood psychiatry[1] permits the blending of clinical skills and community mental health practices. The resulting amalgam, however, is more than the sum of its parts. One's experience is fundamentally different when he/she attempts to become part of the neighborhood and to see and feel things as do the neighborhood's residents. Practice becomes more immediate, more informal; in fact, many practitioners develop a keener sense of life's realities and the client's psychodynamics when practicing in a poor neighborhood and allowing themselves to become part of it. They generate a new appreciation for the strengths, talents, creativity, adaptive capacities, and survival abilities of people with meager material resources. Neighborhood practitioners also develop a real sense for how the mental health program relates to other human services systems, and how the available services fit, or fail to fit, the neighborhoods' social, cultural, political, and psychological characteristics.

If service delivery in neighborhood-based settings expands, we foresee a four-level human services structure carefully linked and coordinated to insure client continuity of care. At Level I would be the primary mental health services provided outside the central facility home base, i.e. in neighborhood health and community centers, welfare offices, job programs, and the like.

Examples of such neighborhood programs are located in Boston's North End Community Health Center, Charlestown's Bunker Hill Health Center, Cambridge-Somerville, and Taunton-Mladieboro; the latter two are described in the following subsection on ambulatory care. Direct clinical services, including consultation and education for other primary caregivers, also are provided at Level I. Particularly appropriate at this level are such aftercare programs as halfway houses, cooperative apartments, day programs, ex-patient clubs, communes, and medication groups.

Level II in such a structure of comprehensive care would be the central mental health facility which is often located within a community general hospital. Here are provided acute, short-term inpatient services as well as ambulatory and emergency care for those who choose to come to a central facility. Levels I and II must be closely linked. In an urban area, this is best accomplished by dividing the catchment area along neighborhood lines with the central program organized into teams linked to specific neighborhood-based personnel.

Level III in this structural model would be an extended treatment facility for patients requiring 90 days to one year of inpatient treatment. This facility, too, is ideally based in the community. Level IV would be a prolonged-treatment program which includes hospital care for those chronic patients requiring it, or alternatively, community-based, prolonged-treatment facilities such as nursing homes, foster homes, and group-living arrangements. Appropriate linkages between Levels III and IV, and between them and Levels I and II should be established and maintained. Quality-control safeguards must be built in, and appropriate regulations for facilities and staffing must be enforced.

Macht, L. B. Neighborhood Psychiatry. *Psychiatric Annals*, 1974 (September), 4, 43-58.

Service 1: Consultation and Education

The 1966 Massachusetts Comprehensive Mental Health and Retardation Services Act (Chapter 735) included mental health consultation and education in its catalog of essential services to be provided in each catchment area. Modeled upon the federal requirement for community mental health programs, the Massachusetts Legislature mandated the Department of Mental Health and its affiliated programs to insure that this indirect service was provided throughout the state along with the several other direct clinical ones. Almost a decade after Chapter 735's enactment, consultation and education services still are ambiguous in nature, varied in quality and focus, and low in overall program priority.

Budgetary data assembled by the Central Office of the Massachusetts Department of Mental Health indicates that in Fiscal Year 1974 an average of only 4.7 percent of an area's mental health budget was expended for consultation and education services to adults and children. This effort level is similar to that found nationally in federally funded community mental health centers.

Nevertheless, the Massachusetts findings are ironic in that much of consultation's conceptual and technical foundation was developed and refined in such Massachusetts settings as the Harvard School of Public Health and Medical School, the Massachusetts General Hospital, the Wellesley Human Relations Center, and the South Shore Mental Health Center. The following analyses and recommendations about the need to expand consultation and education, thus, are built upon both knowledge and skills long familiar to local mental health practitioners as well as some of the newer trends and activities experienced in recent years.

Before turning to the several analytic dimensions significant to our Task Force's work, it would be helpful to define the scope and purposes of consultation and education services. The National Institute of Mental Health defines these services in the following way:[1]

Mental Health Consultation:

> Mental health consultation is the provision of technical assistance by an expert to individual and agency caregivers related to the mental health dimensions of their work. Such assistance is directed to specific work-related problems, is advisory in nature, and the consultant has no direct responsibility for its acceptance and implementation.

Mental Health Education:

> Mental health education is the dissemination of knowledge related to issues and behaviors which contribute to individual and community mental health and mental health breakdown; and knowledge of resources and skills for the achievement of mental health and the management of mental illness. Mental health education includes both theory and practices, general knowledge and training in specific job or task-related skills.

Organizational Auspices

A clear trend exists in Massachusetts toward decreased public operation of the six basic mental health services and towards increased "purchase-of-service" agreements between the state Department of Mental Health and local nonprofit and profit organizations. Another long-evident trend is reduced domination of the mental health service delivery system by psychiatric agencies and increased sharing of these functions among a broader array of human services. What are the implications of these trends for the expansion of mental health consultation and education services?

The National Institute of Mental Health analysis[2] of consultation and education suggested that mental health consultation emanating from a community mental health center differs from that offered out of many other settings, such as private consulting firms, a mental health professional's office, or other human services agencies, in that the purpose and outcome of the consultation and education have importance for the center's programs as well as for the consultee's programs. This is so because community mental health centers aim not only to achieve change in the functioning of individual consultees and through them, their clients, but also to assist agencies and institutions to expand and upgrade their roles in the community's mental health maintenance system.

The responsibility of the mental health system for consultation and education is particularly apparent with regard to ambulatory and hospital services provided persons in acute emotional distress. Although other human services organizations such as

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[1] National Institute of Mental Health. The scope of community mental health consultation and education. Department of Health, Education, and Welfare Publication No. (NIH) 74-650. 1971.

[2] *Ibid.*

the schools and family service agencies may demonstrate increased commitments to primary prevention and the rehabilitation agencies to tertiary prevention, mental health organizations remain unique in their continued commitment to the secondary prevention area. Thus, while a broad array of human services agencies may be expected to expand their consultation and education services just as they are assuming expanded clinical responsibilities, mental health organizations must nevertheless remain committed to consultation and education around issues of acute clinical care.

The question of whether mental health consultation and education should be operated under public auspices or contracted to profit or nonprofit organizations is answered less easily. Public auspices go further toward insuring a systemwide perspective and accountability for consultation and education services while also strengthening their fiscal viability. On the other hand, public mental health agencies overloaded with demands for clinical services may assign a low priority to consultation and education and never generate necessary resources for them. A contract between a local Area Board and a nonpublic agency for consultation and education services insures that these services will be provided at the specified level.

Finally, organizational auspices for consultation and education services must be considered in relation to the population density of the community. In highly populated urban settings where the boundaries of mental health catchment areas are somewhat artificial, consultation and education to certain groups could be provided under regional auspices so as to better conform with the sociology of the community and the geographic responsibilities of other human services agencies. Sparsely populated locales require decentralized consultation and education services and each such catchment area should devise its own uniquely appropriate organizational arrangement.

Program Components

Consultation is conducted with the consultee regarding the referral or management of an individual, family or client group, or regarding the feelings of the consultee about his/her client. Consultation also is concerned with administrative and staff organization and relationships. Problems in relationships occur in the organization of an agency, between agencies and the community, between agencies and agencies, and through conflicts between staff members and between administration and staff. Consultation assists individuals or agencies to assess the nature and genesis of mental health problems and the need for new or modified programs. Consultants may also advise on the planning and development of research, training, or service programs, and on the evaluation of a program.

Consultants utilize consultation for the transmission of knowledge with regard to general human relations, human growth and development, social organization, and special mental health problems. Consultants transmit skills in treatment, training, research, administration, evaluation, and in preparing of written and audio-visual materials. Although consultation may focus primarily on one of these tasks, there may be several shifts in focus even in one consultation session or in regard to one problem.

Many people have found it useful to divide the variety of consultation and education activities into two broad categories—client centered or case consultation, and program consultation. During the past decade, there has been increased effort devoted by mental health consultants to the latter category.

Case Consultation

Case consultation is concerned with the day-to-day functioning of an agency or service and its clients and deals with the interpersonal relations of agency staff and the relationships between the consultees and their clients. The latter may focus on the feelings and reactions of the consultees, on the needs and management of the clients, or on the interaction between client and consultee.

Case consultation not only assists the consultee to manage day-to-day problems but also provides a vehicle for liaison between the direct service staff of community mental health centers and other community agencies and for the dissemination of knowledge and skill in regard to mental health matters to the staff of collaborating agencies. Case consultations sometimes stimulate new mental health interests and capacities on the part of other service personnel and overlap into program consultation. For instance, public health nurses, after consulting on a number of cases, may decide to add to their services aftercare for mental patients or a parent education program at the well-baby clinic.

Program Consultation

Program consultation deals with problems concerned with the planning, development, management, evaluation, and coordination of services directly or indirectly affecting the mental health of the community. Participants in such consultations are generally administrators and planning staff. There is much value in also utilizing former psychiatric patients in these endeavors since they have highly relevant knowledge and experiences. Former patients can make a particularly valuable contribution as program consultants to those services dependent upon high public acceptance, e.g. community residences.

Program Balance

The precise nature of a mental health center's con-

sultation and education program should develop in relation to the organization's goals and priorities, the staff's expertise, the population's needs, and the range of human services caregivers in the community. Program consultation generates highly subtle and complex interorganizational relationships, and particular thought must be given to ways of developing and maintaining this activity.

Many mental health centers have found that their case consultation services, including backup client care, must be adequately established before other organizations will seek and accept program consultation. While the resulting consultation and education program will be unique and vary from area to area, it nevertheless should be founded upon a well-articulated philosophy and set of concepts which recognize that the mental health center is part of a larger human services system. A population's mental health needs cannot be met by the center alone, and the participation of many other human services agencies is essential. Thus, mental health consultation and education should include systems intervention as a key strategy.

An example of how program balance is achieved in consultation and education activities is evident at Boston University's Community Mental Health and Retardation Center. Its consultation and education program identified 178 local, state, and federal agencies which directly or indirectly affect the mental health care of its catchment area population.

During 1972-1973, the Boston University consultation and education program determined that its personnel should be deployed so as to provide episodic program consultation to 74 of these agencies and continuing program consultation to 43 of them. Client-centered consultation was provided to 61 agencies and direct service contacts on behalf of clients were made with 56 agencies. Although the Boston University consultation and education staff related to most of its network through either case centered or program consultation, both patterns were pursued with such particularly relevant human services agencies as the local Visiting Nurses Association and the Roxbury Multi-Service Center.

Finally, consultation and education increasingly are being recognized for their value in furthering continuity of care when more than one human services organization is involved in a client's treatment. This approach has already proven useful in ambulatory settings, it is being developed in day hospitals and aftercare activities, but it is yet to be fully explored with regard to emergency services.

Staffing Patterns

The preceding analysis of the extensive tasks deemed part of consultation and education services makes it clear that far too few resources have been assigned by local mental health centers to these purposes. In rectifying this situation, how many and what types of staff should provide consultation and education, and how should they be organized within the mental health center?

The answers to these questions will remain rooted in the center's conception of consultation and education. Larger staff numbers are assigned to consultation and education by centers which have made consultation the major vehicle for contact with the community. At the other end of the scale, centers which have assigned relatively few staff to this endeavor view consultation only as an indirect service to the community to be provided as need arises.

The organization of consultation and education services within a mental health center also varies. In some centers, consultation is conducted by a separate staff; in other centers, it is combined with direct services such as the ambulatory program. The advantages of the latter arrangement are that where programs are decentralized, travel is reduced and consultation provides a vehicle for case referral, for intimate understanding of local agencies and their programs, and for the development of close relationships between center and agency staff. It is also possible to better understand when clients are referred and whether the problem lies with the patient or the agency.

However, program and administrative consultation undertaken between administrative personnel may demand skills not always possessed by clinical staffs. It, thus, makes sense in some situations to differentiate organizationally between program and case consultation. Furthermore, when working with the court system even when the focus is on the case consultation, many assert that clinical staff cannot readily consult with legal officials. The gap between mental health and legal values and concepts is deemed so broad that specially trained mental health consultants are needed for this task.

The range of staffing options and organizational patterns appropriate to major consultation and education activities can best be illustrated through brief descriptions of some Massachusetts mental health programs which have committed significant organizational resources to this essential service.

1. **Boston University Community Mental Health and Retardation Center.** As the recipient of a National Institute of Mental Health staffing grant for consultation and education service, the Boston University Center expends far more resources for this program component than does any other center in the Commonwealth. The Boston University consultation and education program directs its efforts toward community organization and advocacy and although limited direct services are provided local residents, the consultation and education teams primarily focus upon continuing client and

program consultation. This orientation is reflected in the consultation and education program's structure and staffing pattern. Functioning as a semi-autonomous component of the Boston University Center, the consultation and education program has its own director and staff. During 1973, the 30 consultation and education personnel included three psychiatrists and four social workers, but a third of the consultation and education staff consisted of community workers capable of linking the Boston University Center with the local human services network.

2. **South Shore Mental Health Center.** Many of the consultation concepts and techniques now commonly utilized throughout the country were pioneered and refined at this Center. For many years, the consultation and education staffing pattern consisted of several psychologists who specialized in this service and who devoted the bulk of their workweek to case and program consultation in the community. However, in the early 1970s the Center shifted to a generalist model for community consultation and most staff now provide both clinical services and consultation. In 1973, the Center's management information system revealed that 12 percent of all measurable staff service hours were devoted to consultation with schools and agencies. Dr. Van Buskirk, the Center's Director, judged such a proportion of staff effort to be reasonable for a mental health program engaged in extensive clinical activities including hospital care. If inpatient and day hospital services are not part of a center's responsibility, he thought that consultation and education activities should comprise approximately 20 to 25 percent of a center's workload.

3. **Massachusetts Mental Health Center.** One of the few consultation and education programs focusing upon the needs of elderly persons is the Geriatrics Unit of the Massachusetts Mental Health Center. The Unit, comprised of one full-time psychiatrist, two social workers, two nurses, three students, and several volunteers, is responsible for both the Center's clinical and mental health consultation services to geriatric persons in the catchment area. First established in the early 1970s, the Unit has found that when the mental health needs of the elderly are viewed broadly rather than narrowly, many other human services agencies can fulfill tasks previously assigned to the Massachusetts Mental Health Center. Dr. Gurian, the Unit's Director, indicated that in mid-1974 only about 10 percent of this staff's time was spent in direct clinical services; most personnel hours involve case and program consultation to the diverse local health and social welfare agencies dealing with the elderly.

Consultation Skills

The varied consultation models described here suggest that individuals filling this role should be selected with the same care and concern exercised in the selection of clinical personnel. The National Institute of Mental Health's analysis of consultation and education programs concludes that the most important criteria for selecting consultants are personality and competence, capacity to relate to people, and ability to develop trust and confidence.[1]

However, other factors may also be relevant. Sometimes a consultee will have strong feelings about the profession, religion, race, age, or sex of a consultant. It may be important to have a consultant from the same profession or to have a consultant who is or is not a physician. Sometimes the consultant must be from the same ethnic group. Most times this is irrelevant. Some people find it easier to accept advice and assistance from a man; others from a woman. Most frequently, these initial preferences can be overcome by a competent consultant.

Facilities

The majority of case and program consultation occurs in the consultee's home setting. Office space is the only facility required by mental health consultants within the center itself. In fact, where center staff specialize in consultation and education services and spend much of their time in community agencies, it may be possible for mental health consultants to obtain office space within these agencies. If the mental health center operates on a decentralized basis through satellite facilities, consultants working with local human services organizations should be located in these "field stations" rather than in the center's "headquarters."

Costs

In contrast to other basic mental health services whose costs include personnel plus physical facilities (possibly even bed space), consumable supplies, medications, equipment, etc., personnel salaries and fringe benefits are the primary cost of supplying consultation and education services. Nevertheless, staff salaries comprise 70 to 80 percent of the total budgets of mental health centers; thus, the cost of consultation and education will be related closely to the salary level of those personnel providing it. Hourly rates generally are highest for psychiatrists and lowest for nonprofessionals. If

[1] National Institute of Mental Health. The scope of community mental health consultation and education. Department of Health, Education, and Welfare Publication No. (NIH) 74-650. 1971.

more than one center staff person participates in a consultation session, as in group or team consultation and joint supervisor-student arrangements, consultation and education expenses increase accordingly.

The true cost of a specific mental health service, clinical or nonclinical, had been unclear until recent years when third-party reimbursers forced mental health administrators to calculate this information more precisely. However, outside reimbursements by and large remain unavailable for consultation and education, and so few centers have determined the specific cost of this service. An exception is the South Shore Mental Health Center which projected that in Fiscal Year 1974, consultation would cost $25 per hour to schools and $33 per hour to other community agencies, a reduction from the $30 and $35 rates of the previous year. This estimate for consultation and education contrasts with the South Shore Center's projected average cost in 1974 of $36 per hour for evaluation and treatment services to patients.

If consultation and education service costs can be generalized to other mental health centers from the South Shore Center's fiscal experience, administrators and planners may anticipate that this component of a comprehensive program can be expanded at 8 percent to 30 percent less expense than would be needed for expanding direct patient services. Furthermore, the ability of sophisticated mental health consultants to reduce the clinical demands upon their center makes consultation and education a particularly cost effective program element.

Income Sources

Mental health centers have been increasingly successful in diversifying the fiscal base for their varied program activities. Other sections of this Manual point to the multiple insurance mechanisms and to the federal reimbursements now existing for direct patient services. Unfortunately, this improved fiscal pattern has not benefited consultation and education services yet. State or local public funds continue as the prime support for this program element.

There are many reasons why this is the case. Consultation and education are relatively new as a mental health program component, profound problems are entailed with demonstrating its effectiveness, and funding sources are reluctant to support indirect clinical care. However, the present fiscal difficulty also is related to the unwillingness and/or inability of most mental health centers to generate a buyers' market for consultation and education services. It is highly probable that these services will become reimbursable when other human services organizations perceive a need for them and express this need as a "demand" in the human services "marketplace." This economic principle has pertained to other mental health services; it holds true for consultation and education as well.

In Massachusetts, the costs of consultation and education provided by Department of Mental Health clinics generally are borne by state funds. Even the South Shore Mental Health Center, which for years has been providing consultation and education to schools and other agencies in its catchment area, receives little local reimbursement for this service. A bright exception in a generally bleak fiscal picture is the Laboratory of Community Psychiatry of Harvard Medical School's recent contract with the Boston School Department to provide it with program and case consultation.

The recently negotiated arrangement betwen mental health clinics and public welfare offices for Medicaid reimbursement of mental health case consultation may be the harbinger of a fiscal breakthrough. Under this arrangement, the case consultation provided by mental health personnel to public welfare caseworkers about Medicaid-eligible clients can be billed at the same rate as direct clinical services. It is expected that significant revenues will be generated in this way. Another potential revenue source for case consultation is the service provided by mental health personnel to public schools in accordance with Chapter 766's requirements. The full potential of this program is yet to be explored.

Service 2: Emergency Services

An "emergency" is defined by Webster's Dictionary as "an unforeseen combination of circumstances which calls for immediate action." American society has developed a system for handling medical emergencies through a network of public and private physicians, nursing services, and hospitals. In Massachusetts, the system is being vastly improved and expanded under the Department of Public Health. Society also has made provisions for dealing with large scale disasters through the National Guard, Red Cross, Civil Defense, etc. although the efficacy of these interventions sometimes is less than optimal. The crises of everyday life, however, are dealt with, if at all, by the Department of Mental Health, the Department of Public Welfare and/or some combination of private agencies working in rather haphazard ways. The need for increased planning and coordination among these helping organizations is apparent to everyone, but the means by which these ends may be achieved are not as readily evident.

No state, or even foreign country, thus far has evolved a comprehensive human services network capable of handling psycho-social emergencies and/or crises except perhaps in times of war. While there is much recognition of the need for developing techniques of effective crisis intervention, there is a paucity of information on how to structure such a service with necessary network linkages. An additional present difficulty is that few emergency psycho-social services exist in suburban and rural areas. Nonetheless, the "ideal" pattern for a broad spectrum human services crisis-emergency team capable of dealing with virtually any kind of psycho-social crisis may be inferred from both the literature and our experiences.

Crisis intervention literature makes abundantly clear the many stressful events which can have a destructive impact on people's lives. From this broad perspective, the narrowly defined "psychiatric emergency" is only one of many possible psycho-social situations having legitimate claims on the time, attention, and funds of the Department of Mental Health and Executive Office of Human Services. Ultimately, it is less expensive to the taxpayer as well as more humane if in crisis situations the necessities of people's lives (i.e. food, clothing, shelter, protection, understanding, etc.) are supplied along with medical care.

Despite the logic in this conception of human emergencies, very few geographic areas in Massachusetts are at this time in a position to implement a full scale Human Services Crisis-Emergency Service. In most areas, general hospitals, police departments, and state hospitals are the only social agencies open between 5:00 p.m. and 9:00 a.m. A narrowly defined Psychiatric Emergency Service would, therefore, add during the evening, weekend, and holiday hours only counseling and perhaps transportation to the limited services of which most people already are aware. When the basic array of alternative human services exist and where these services can meet Department of Mental Health requirements, the geographic area could support a Human Services Crisis-Emergency Team of the type to be described here as the ideal. These teams also should serve as laboratories for research, generating the information so necessary to a viable service network.

Organizational Auspices

Crisis intervention services typically evolve from an organization's perception of community needs, e.g. the 24-hour walk-in psychiatric services at Massachusetts General Hospital and the Massachusetts Mental Health Center, or from a person's inspiration around a concept, e.g. the Samaritans, a worldwide volunteer organization formed to prevent suicide by using the telephone as its chief means of communication. As Americans on the whole become more psychologically sophisticated, it is increasingly common to find organizations such as the police or legal agencies adding a psycho-social component to serve their constituency. The Boston Police Department has hired five workers to provide social services in as many police stations. The Boston Legal Assistance Project, a federally funded legal agency for certain poverty areas, also has a social services unit. The Episcopal Church has trained groups of bartenders to do crisis counseling in taverns and lounges. There are undoubtedly as many patterns for organizing emergency services as there are institutionalized styles of human relationships.

In most areas of the Commonwealth of Massachusetts, minimal psychiatric emergency services are available through local police departments, general hospitals, and state hospitals which are on call 24 hours each day of the year. If the area wishes to provide added services so as to broaden its capacity to respond in emergency situations, it might sponsor hotlines run by trained volunteers and even perhaps several teams which go into the community. However, we now have sufficient experience to know that such services neither function adequately nor last for an appreciable time unless they are preceded by systematic planning which generates

the support of all important community elements.[1] When these steps are taken, volunteer-operated services frequently have proved more available on an around-the-clock basis than have professionally operated ones, and they elicit greater community support and interest. If a hotline format is chosen, the Area Board must decide whether the service primarily will serve adults or teenagers as the two client groups currently prefer not to use the same service.

If the Area Board, Area Director, and the local community planning council determine that an explicit psychiatric emergency service is needed, several models can be examined. The Massachusetts Mental Health Center—a state facility—does not differentiate its emergency clinic in any way from the outpatient department. Psychiatric residents, psychologists, and social workers cover the walk-in emergency service as part of their outpatient responsibility. Assigned psychiatry residents provide night, weekend and holiday coverage.

Massachusetts General Hospital has a well known acute psychiatric service operating 24 hours per day all year long. During the day, it is staffed by a combination of psychiatric residents, students and other mental health professionals who rotate between this service and the outpatient department (a separate service). At other times, coverage is provided by psychiatric residents either on duty or on call to the acute psychiatric service as well as by other Massachusetts General Hospital services, e.g. the surgical service.

Union Hospital in Lynn, Massachusetts is using a federal grant to field personnel, usually an R.N. and a "mental health professional," at prominent geographical locations in the area during the day. Dr. Jackson Dillon, the former director, and one of the nurses occasionally were called after hours. A psychologist and a psychiatric nurse make emergency home visits whenever required in the Lynn Area.

When it is felt that greater psychiatric coverage is needed in a public or private hospital having an inpatient psychiatric unit, psychiatric residents and other mental health professionals such as psychologists, social workers, and psychiatric nurses should be on duty or on call.

The preceding emergency service models, i.e. the volunteer, the general hospital, and psychiatric hospital, have all been found workable over long periods of time. They have the additional advantages of readily interlocking with components already available in the social service delivery network in Massachusetts, and of being applicable to any geographic area. In choosing a model for meeting emergency service needs, community planners along with the Area and Regional Department of Mental Health Offices should give careful consideration to such issues as geographic scope of the service (area v. community v. regional), characteristics of involved agencies (public, private, centralized, decentralized, etc.), capacity of existing emergency services to meet current community needs, and capacity of existing services to evolve into the projected Human Services Crisis-Emergency Team model.

As previously stated, the desired evolution in the local emergency service should be from a small volunteer organization to an extended psychiatric service to a comprehensive Human Services Crisis-Emergency Team. It should be capable of providing coverage at a minimum, 5:00 p.m. to 9:00 a.m. on weekdays, weekends, and holidays. A broad variety of service options should range from information and referral to intensive crisis intervention counseling[2] to alternate forms of physical shelter.

Ideally, the Crisis-Emergency Team should be established as an independent human services program fiscally and functionally separate from other public and private agencies such as community mental health centers. The separation of Crisis-Emergency services from any one organization has generally proved more effective in fostering cooperation and linkages with other agencies. Emergency services established as an appendage to another organization frequently have been reabsorbed into the parent body since emergency programs and their personnel tend to be perceived as an irritant. Not only do emergency services by their very nature have time pressures which differ from those of all other human services, the tasks, the styles of approach, the types of staff, plus many other variables also differ markedly.

The concept of the comprehensive Crisis-Emergency Team squarely confronts the care-giving system with a major dilemma: Neither people nor their problems come in neat packages despite the valid need of care-giving persons to clearly delimit areas or responsibility. The Crisis and Emergency Team must be able to insure active cooperation on every level within the public human services network, including such important organizations as the police, fire department, family agencies,

[1] McGee, Richard K. *Crisis Intervention in the Community.* Baltimore, Md.: University Park Press, 1974. See Chapter X, "The Historical Development of 10 Programs."

[2] A useful model would be the crisis intervention center currently overseen by Howard Parad, Ph.D. in California. Clients at any level of crisis are given the option of attending any of six intensive psychotherapeutic crisis groups.

ministry, business organizations, etc.[1] Thus, the director of the "ideal" Crisis-Emergency Team optimally should report directly to the Mental Health Area Director or, in the future, to the person designated as having final responsibility for public human services programs on an areawide basis.

Program Content

Extensive community resource networks often either do not exist or are not perceived as existing despite the wide variety of helping persons potentially available in any community.[2] The program content for newly established emergency services, thus, probably will be limited to crisis counseling, aiding those in need of psychiatric hospitalization, and forming ties with existing services and agencies.

The experience of most existing crisis-emergency agencies has been that no matter how clearly they initially delineated their specialty (e.g. suicides at the Los Angeles Suicide Prevention Center, or adolescent runaway and drug problems at Boston's Project Place), in time they inevitably come to deal with a far wider spectrum of problems. Thus, ostensibly specialized psychiatric services such as the Massachusetts General Hospital's Acute Psychiatric Service and the Massachusetts Mental Health Center's Walk-In Clinic added staff social workers not only for their clinical skills, but also for their abilities to mobilize the larger environment. It is likely, therefore, that crisis teams initially established with narrowly defined responsibilities to psychiatric patients inevitably will evolve into more broadly conceived Human Services Crisis-Emergency Teams.

If the area decides to design a *nonpsychiatric* emergency program, a number of Massachusetts agencies have the relevant experience and capacity to train personnel for these types of services. For example, 735 Inc. in Melrose and Project Place in Boston have highly developed teen and drug counseling hotlines; and the Samaritans, a worldwide volunteer suicide prevention group based at Arlington Street Church in Boston, use hotlines and "befriending" to aid those in trouble. These agencies also can teach the art of negotiating links with the other agencies necessary to fulfill organizational objectives.

Dr. Jon Gudeman, Director of Outpatient Services at the Massachusetts Mental Health Center, has a differing view. He has observed that any emergency service, e.g. police, hotlines, and suicide centers, not directly linked with an inpatient psychiatric service functions at a disadvantage since, in at least some instances, it must refer clients to an inpatient service for possible admission. Furthermore, many people approach nonpsychiatric services for referral to inpatient facilities either because they do not know of the existence of inpatient facilities or because they feel more comfortable approaching inpatient facilities with the support of nonpsychiatric emergency service personnel.

Each area must decide whether direct access to the inpatient psychiatric unit, or indirect access via a nonpsychiatric emergency service best meets the area population's needs. It should be recognized, though, that emergency services intimately connected with an inpatient psychiatric unit, under either public or private auspices, often develop a degree of trust with inpatient workers which facilitates the decision-making process regarding hospitalization. Trust is most likely to exist where inpatient and emergency service workers have been trained on both types of services.

An emergency service which is part of a psychiatric facility could offer program coverage in greater depth and at less expense if the legal right (Chapter 123, Section 12) to admit patients for 10 days of involuntary psychiatric observation is extended to nurses with Master's Degrees in Psychiatric Nursing, social workers with Master's Degrees of Social Work, and licensed psychologists.

Although this may seem a radical suggestion, in many mental health centers the current practice is to provide nurses, social workers and psychologists with master's degrees, 10-day voluntary commitment forms presigned by a psychiatrist. It is recognized that persons thus trained are as able to judge the necessity for hospitalization as those psychiatrists who may have less experience. Moreover, the police already have the power to bring persons to hospitals for involuntary psychiatric observations. It is a virtual necessity in their daily work even though they are hesitant to use this power. In the light of these realities, legal recognition and protection should be extended to the highly trained mental health personnel who are expected in the course of their jobs to admit patients for involuntary observation. This legal right should adhere to a specific Department of Mental Health job slot or function and would be extremely useful in rural and suburban areas where immediate evaluation by a "designated physician" often is not possible.

The need to adequately protect the civil rights of persons who may become patients must receive the highest priority under existing as well as proposed

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[1] Jackson Dillon, M.D., formerly of Union Hospital in Lynn, won the American Psychiatric Association medal for the emergency services which he directed in the San Joaquin Valley of California, an area geographically comparable to Massachusetts. Dr. Dillon strongly advocates organizing an emergency service from its inception by meeting with all important community elements, especially the family agencies, fire department, police, business organizations, ministry, etc.

[2] Curtis, R. Team Problem Solving in a Social Network. *Psychiatric Annals*, Dec. 1974.

procedures. Emergency service personnel, whether operating from a hospital or a nonpsychiatric service, must routinely inform both the prospective patient and any other interested parties such as family and friends of the prospective patient's civil rights. Moreover, all persons with the power to admit patients for involuntary observation should pass a course on the civil rights of patients and then be held legally accountable for insuring that these civil rights are protected.

A nondiscriminatory admissions and treatment policy can be maximized in practice by appointing a person from another agency (preferably legal) to act as patient advocate for all psychiatric programs licensed by the Department of Mental Health in a mental health area. The Mental Health Legal Advisors established under Chapter 221 could serve this purpose. The Advisor's name, telephone number, and functions should be posted conspicuously and clearly in every admitting room and inpatient ward of Department of Mental Health-licensed facilities. In addition, all emergency service personnel should be legally required to give each prospective patient a card bearing the patient advocate's name, phone number, and functions.

Each area emergency service, whatever its organizational auspice, should be required by regulation to document every request for service whether made by telephone or in person. The disposition of each such request should be adequately accounted for in a recordkeeping system. If the applicant for emergency service is referred to any other human services program, e.g. an inpatient or outpatient mental health facility or community residence, that program and a specific person on its staff must be designated as agreeing to assume further responsibility for the applicant.

Any therapeutic modality deemed appropriate, by both Area Board and Department of Mental Health standards, may be used as long as the patient signs a written agreement consenting to the specific type of treatment or emergency plan. This agreement should be reaffirmed when any new modality or location of treatment is undertaken unless that patient is physically dangerous to self or others.

All personnel working for an area emergency service should possess identification such as a badge with personal photograph which is recognizable to Department of Mental Health personnel in any of the area's other services, i.e. inpatient, outpatient, partial hospitalization, community residences, rehabilitation programs, geriatric, children's programs, and consultative and educational services. A request for patient service by staff of the emergency service should take priority over other responsibilities such as staff meetings.

Staffing Patterns

Personnel operating an emergency service should possess the skill, experience, and language fluency appropriate to the service's clients. This is most readily insured when staff reflect the characteristics of the population as a whole in terms of sex, socioeconomic background, and educational attainment. Thus, the team members should include men and women, and as many persons as possible from the ethnic, racial and/or language groups served. As a corollary, clients should be given the choice of meeting with staff possessing the characteristics meaningful to them.

If the emergency team is to function as a true Human Services Crisis-Emergency Service, it should be staffed so that at least one member of the team is:

- Able to relate to children and teens.
- Knowledgeable in suicide prevention techniques and able to consult with other staff members on them.
- Recognized by the community as being one of its own (i.e. from the culture being served).
- Familiar with women's special problems such as rape.
- Knowledgeable about the civil rights of persons needing emergency help.
- Personally experienced in mental hospitalization (outpatient treatment is not a substitute).
- Sophisticated in treatment of alcohol and drug problems.
- Knowledgeable about geriatrics.

The team should also possess the skills cited in U.S. Public Health Service Publication 1477 as particularly valuable to emergency services, i.e. maturity, capacity for warmth and empathy, trainability, and some experience in life. Staff also must have demonstrated capacities in their lives for initiative, independence, and judgment (scholastic achievements are not necessarily indicators of the above characteristics). In order to insure these capacities, it will be necessary for the Department of Mental Health to evolve job-related screening procedures which measure these attributes.

The range of individuals among whom necessary skills can be found include volunteers, professionals, and other paid staff. Most hotlines are staffed largely or wholly by volunteers including extremely dedicated professionals who provide every-other-week, round-the-clock coverage. The obvious advantage to a "volunteer" staffing pattern is that costs are minimized even though training is required. The service can thus provide expensive coverage at minimal expense. On the other hand, it may well be necessary to have additional volunteers on duty simultaneously so that they can pool their knowledge and emotional strengths in dealing with crisis situations.

Staffing an emergency service with professionals is expensive but, on the other hand, these personnel do not need additional training and they are capable

of making reasonably appropriate decisions under stress. Ann Fried, Director of Casework Services at Family Service Association of Greater Boston, Inc., has had many years of experience with both professionals and volunteers. She suggests that the great advantage of professionals is their trained ability to discriminate what crises they can handle directly and which they should refer. She estimates that it takes a minimum of two years to perfect this judgment as well as to fully differentiate one's own needs from those of the client. However, she acknowledges that the highly trained volunteer can be as useful in a particular situation as the professional.

Nonprofessional paid staff is a third staffing option. Most hotlines use some nonprofessional paid staff who coordinate and fill in those time slots left uncovered by the volunteers. Such staff often develop specialized skills beyond those of the volunteer and even those of highly experienced professionals. For example, drug emergency teams are often much better able to cope with related crises than are psychiatrists and social workers who are unfamiliar with this population and unaccustomed to making decisions without the security of an agency structure. Nonprofessional paid staff are common on most psychiatric hospital wards, and studies have shown that some attendants have more understanding for and better technique with selected patients than do the professionals.

Unfortunately, the people who make decisions (such as Area Directors) tend to be upper-middle class professionals, and they may exhibit a class bias against, or at the very least a lack of understanding of, the nonprofessional's capability. Yet, with the exception of the drug culture which is also middle-class at least in its services, middle-middle, lower-middle, or working-class nonprofessional paid staff are more apt to understand the background and problems of the majority of clients since they emanate from similar backgrounds.

The ratio of staff to patients on an emergency service cannot be precisely delineated as emergencies happen to varying numbers of people at differing times. Therefore, the emergency service team must have an on-call backup group composed of volunteers, consultants, and other resource people. Hotline emergency services find it necessary to have on duty a minimum of two people and preferably four at all times. The hotlines operated by such agencies as Project Place need two people just to cover the telephones, but psychiatric clinics such as those at Massachusetts Mental Health Center and Massachusetts General Hospital's Acute Psychiatric Service often "make-do" with only a secretary since the psychiatric resident is frequently on call in another part of the hospital. To a major extent, the economics of the situation will dictate the type and amount of staff time available.

Facilities

The physical setting most appropriate to an emergency service is obviously where the emergency is occurring, with the option of removing the client to a calmer environment if necessary. Thus, equipment such as beepers, mobile units, closed circuit TV, hotlines, etc., are considered as important as the physical facility itself which should be homelike rather than institutional. Many people become even more distressed in an institutional setting; indeed some people in crisis recall the physical setting where they sought help as the worst part of the experience. Stress may be minimized by meeting with clients in offices which have a pleasant atmosphere, comfortable chairs, refreshments, rugs, plants, pictures, etc.

Traditional settings and nontraditional settings evoke a wide range of responses. The setting of an emergency service, therefore, optimally should embody both the sense of order and security conveyed in the best of traditional settings, and the feelings of warmth and empathy found in the best of nontraditional settings. Emergency services are operated in each of the following settings, and research on their unique advantages and disadvantages would be of great value.

1. **General hospital emergency rooms** provide immediate medical care, but the psychiatric staff and their clients tend to "clutter up" space and clash with the medical staff. Use of other space in a general hospital is useful, on the other hand, many people will not use a hospital emergency service that defines them as "sick." Nevertheless, many emergency services provided in general hospitals are covered under medical insurance plans and, thus, are fiscally solvent. The Massachusetts General Hospital Acute Psychiatric Service is an example of how this model should function optimally.
2. **Mental health centers** permit many emergency problems to be paid for as "medical" in character, but again many people will not seek help under these circumstances. Also, it is harmful to define people as "sick" when their crisis is related to the fact that they are destitute, etc. Massachusetts Mental Health Center's program is a good example of how to provide emergency services in this type of setting.
3. **Counterculture settings** often provide a warm, intimate setting, but only for members of the counterculture. Older people, for example, are often frightened by the apparent lack of organization, pictures on the walls, etc. Where a large effective counterculture group does indeed exist, such settings are useful and should be considered eligible to receive state contracts, for example, 735, Inc. in Lawrence.

4. **Clergy and police stations** have devoted followings who initially bring all of their problems to these caregivers since they are perceived as natural emergency service personnel. In fact, the Boston Youth Activities Commission and the Boston Police currently employ social workers in police stations.

5. **Hotlines located in independent facilities** such as the Arlington Street Church, Boston, are very useful when they include adequate private space for discussions with applicants, and accessibility to medical, legal, and police help. Unfortunately, these facilities are also the hardest to fund and maintain since they rarely can charge other groups for the services which they deliver. Good examples of hotlines are Samaritans, Inc. at Arlington Street Church and Project Place, in downtown Boston.

Costs

It is almost impossible to estimate the costs for a comprehensive psycho-social emergency service as relatively few such services exist yet and none are comparable to any other. Moreover, even existing psychiatric emergency services which in many respects serve as working models have not costed out their services in a fashion useful to others. Thus, the following data are suggestive rather than definitive.

The Massachusetts Mental Health Center's 24-hour walk-in service also serves as the outpatient department. It anticipated Fiscal Year 1974 expenses of approximately $220,000 for an estimated 7,150 patients, 10 to 15 percent of whom are classified as emergencies. On this basis, $33,000 a year is expended for 1,073 emergency patients, or a cost of $30 per patient visit.[1]

The Accounting Department of Massachusetts General Hospital does not break out costs by clinic, service, unit, or standard figure per square foot. It estimates that the Acute Psychiatric Service costs $250,000 a year to maintain after income and grants.[2] The average cost per patient visit is $47 regardless of whether it is to the surgical, medical, or psychiatric service.

Project Place has a very detailed accounting system which has determined that the Place Van Emergency Services, a van staffed by trained ambulance technicians, costs about $133,000 a year to operate. Project Place's house for short-term care of runaway adolescents runs about $128,000 a year. Both of these Project Place services use about 10 percent volunteer staff while the hotline, "Place Switchboard," uses 60 percent volunteer staff. The hotline costs approximately $85,000 per year.[3]

The Lynn Union Hospital Psychiatric Service has asked for a total of $280,000 for Fiscal Year 1975 for emergency psychiatric services. Of this, $212,000 would be for staff salaries and fringe benefits for two nursing coordinators, five R.N.'s, four mental health professionals, i.e. LPN's, and two mental health workers.

The Lawrence Area Board is requesting three full-time Bachelor's Degree Social Work staff and one full-time secretary to add to the Social Service Department of Bon Secours Hospital. These workers will provide additional day-time and on-call coverage, 24 hours a day, seven days a week. The approximate costs for the first year of the Lawrence system are listed in Table 2-4.

Given the inflationary cost of living and other imponderables, it would be foolhardy to anticipate the cost in several years of the ideal human services crisis-emergency network operating on an areawide basis. Yet, it is reasonable to assert that the cost will be less, both financially and emotionally, to each citizen when a human services crisis-emergency network is in place to resolve psycho-social emergencies.

Income Sources

Existing emergency services are financed in part or wholly through a combination of funds from foundations, trusts, state and federal government agencies, charities, third-party payments, and donations. More specifically, the Massachusetts General Hospital's Acute Psychiatric Service, as part of a medical facility, is able to collect third-party payments. This service also receives grants; the rest of its costs are defrayed by the Hospital Corporation.

During Fiscal Year 1974, Project Place received designated monies from the National Institute of Mental Health, the Massachusetts Department of Mental Health, the Massachusetts Department of Youth Services, the Massachusetts Division of Family and Children's Services, and six foundations and trusts. It received unrestricted funds from 12 trusts and foundations and various churches, religious groups, corporate contributions, private donations, payments for services, and "miscellaneous."

The Massachusetts Mental Health Center is a state facility so that most of its income is from public funds which covers staff salaries for those operating

[1] Information given by the Business Office of the Massachusetts Mental Health Center, Ms. Catherine Hurley, Business Manager.

[2] Information given by Mr. Phillip Lenz, Administrator for Psychiatric Services at the Massachusetts General Hospital.

[3] Information given by Project Place Treasurers Tracy Barnes and Stanley Phillips.

Table 2-4. Lawrence Area Emergency Services: Approximate First-Year Costs

Year 1	Mass. Department of Mental Health	Bon Secours Hospital	Total Cost
Staff	$43,240.00	$14,320.00	$57,560.00
Equipment and Overhead	1,910.00	6,875.00	8,785.00
Supplies	300.00	280.00	580.00
Total First Year Cost	$45,450.00	$21,475.00	$66,925.00
Percent	68%	32%	100%

the service. The Lawrence Area hopes to combine a state grant with income from a local private hospital to maintain emergency services.

When the nation's economy is functioning well, an emergency service can derive or supplement its revenue through grants obtained from federal, state or private sources. Similarly, contributions and donations are more apt to be forthcoming when the general population feels financially secure. Unfortunately, grants of all types, contributions, and donations tend to "dry up" during economic recessions. Ironically, times of economic recession are the very ones when heavy demands are placed on emergency services. State Civil Service job blocks provide a more stable economic base for emergency services and so perhaps should be the fiscal foundation. Grants and other fiscal sources could then be used as supplemental income sources. It is hoped that insurance companies will soon develop necessary actuarial tables so that emergency service costs can be reimbursed to clients through such carriers as Blue Cross and Aetna. It also is hoped that emergency services themselves will become the principal beneficiaries of trusts left specifically for these needs.

Research Recommendations

No state or country has yet devised a systemwide network of emergency psycho-social services, and no systematic comparative study has been made of existing crisis-emergency services. Research should be directed toward any or all of the following:

- The organizational structure of crisis-emergency teams relevant to given demographic conditions and internal team structures most conducive to productive work.
- Program content according to types of activities most utilized by the public.
- Types of job-related skills and personality characteristics most useful in crisis-emergency team members.
- Comparative studies of types of facilities and their effect on service delivery and studies of comparative stress-relief experienced by people in crisis.
- Comparative costs related to amount and kinds of services delivered by different organizational structures, specifically, volunteers compared to nonprofessionals and professionals.

Service 3: Ambulatory Services

The services traditionally labeled "outpatient" are now more frequently being termed "ambulatory" to emphasize the mobility of staff providing them and clients receiving them. This development clearly is part of the larger trend toward service decentralization. Just as we are moving away from providing inpatient services in large state hospitals, so are we evolving new patterns of ambulatory care in convenient and accessible locations. Rather than being concentrated in central facilities, subarea, municipality, and even neighborhood sites now are being utilized for this purpose. As a consequence of this development, the target populations for agencies providing ambulatory services may be as low as 10,000 people. The trend towards decentralization shows no signs of abating and, therefore, fresh organizational choices for structuring ambulatory care are increasingly feasible.

Organizational Auspices

The largest volume of ambulatory services traditionally has been provided by state-sponsored clinics and community mental health centers. Probably the fastest growth in terms of client volume and fiscal expenditures is occurring, among private sector nonprofit and private proprietary organizations. This is due to the increased willingness of the public sector to contract with the private sector through purchase-of-service agreements as well as to the growth of third-party payment mechanisms. Recently established procedures to utilize the Medicaid program for reimbursing local clinics for various mental health services will enable many more agencies in the human services system to provide additional ambulatory treatment or counseling services.

Since people in various socio-economic and ethnic groups and geographic settings tend to favor certain types of agencies, the growing diversity of helping resources is a most positive development. Ambulatory care can be appropriately sponsored by general hospitals, comprehensive community mental health centers, social service agencies, neighborhood health centers, settlement houses, universities, and similar agencies. It is not the organizational auspice which is crucial but rather the nature and quality of the service rendered. Proliferation of the ambulatory care network has major implications for procedures whereby program coordination can be insured. An affiliation contract is one method for facilitating interagency communication and the details of this arrangement are described in Section IV.

Ambulatory services to adult psychiatric offenders continue to be provided primarily through the Court Clinics program of the Department of Mental Health's Division of Legal Medicine. Thirty-one such clinics are now operating throughout the state.

Program Content

Ambulatory care may be considered as including a variety of services designed to achieve the following:

- Keeping the client functioning and out of a hospital setting;
- Fostering client rehabilitation and/or psychological growth;
- Assisting the family as part of the client's problem-solving;
- Identifying and treating more longstanding problems of the client and his/her family;
- Working with a variety of other community caregivers with a focus on the client; and
- Linking with other community systems to improve the quality of life by modifying environmental conditions.

Ambulatory care can be categorized[1] into three major types: (1) information, screening, referral; (2) problem evaluation, examination, assessment; and (3) treatment or counseling services. These services should be delivered within a philosophy of outreach, prevention, and early identification with the strongest emphasis being placed on the idea of involving clients and their families in the process. At various stages, including diagnostic, treatment planning, and review conferences, the clients and their families should be told the details of what is occurring.

1. **Information, screening, and referral services** relate to the availability, linkage, and recipient's eligiblity or suitability for the programs of the agency or other agencies. The component parts are:
   - Information services provide data about the availability of crisis intervention, 24-hour emergency (non-face-to-face) services, and similar activities;
   - Screening, which includes suitability determination, is a service intended to provide information about the availability or eligibility of a person for another organization's services; and preliminary assessment, i.e. delimitation of the type and extent of the problem of the individual seeking help by persons competent to make such judgments; and

[1] National Institute of Mental Health. Definitions of Terms in Mental Health, Alcoholism, Drug Abuse, and Mental Retardation, Department of Health, Education, and Welfare Publication No. (ADM) 74-38. 1973. pp.36-37.

- Referral services direct, guide, or link the recipient to other appropriate community resources.

2. **Problem evaluation, examination, and assessment services** identify the detailed nature and extent of the recipient's condition and formulate a plan for services. The different kinds of evaluation are defined below:
   - Psychiatric evaluation is the psychodiagnostic process, including a medical history and mental status which notes the attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the person's assets.
   - Psycho-social evaluation is the determination of the social situation of the individual related to family background, family interaction, living arrangements, psycho- or socio-economic problems, treatment evaluation, and statement of future goals and plans.
   - Psychological evaluation and testing are the evaluations of cognitive processes and emotions and problems of adjustment in individuals or in groups through interpretation of tests of mental abilities, aptitudes, interests, emotions, motivation and personality characteristics, including the interpretation of psychological tests of individuals.
   - Physical evaluation is the examination of the body, noting observations and findings supplemented by diagnosis if indicated.
   - Neurological evaluation is the examination of the central, peripheral and sympathetic nervous system, noting observations and findings supplemented by diagnosis if indicated.

3. **Treatment or counseling services** relate to the reduction of disability or discomfort, amelioration of signs and symptoms, and changes in specific physical, mental, or social functioning. There is need for considerable flexibility in carrying out treatment services and depending upon specific circumstances they may include.
   - Individual treatment or counseling such as supportive psychotherapy, relationship therapy, existential therapy, play therapy, hypnotherapy (with or without the use of drugs), and casework.
   - Behavior modification through systematic application of learning theory and principles.
   - Collateral treatment or counseling of the patient through interviews beyond the diagnostic level with collateral persons without the patient necessarily present although the patient's approval should be obtained as a matter of good clinical practice and ethics.
   - Couple therapy of intimate partners whether married or unmarried, but excluding other significant family members, children, or siblings.
   - Family treatment or counseling applied to the family as a unit.
   - Group treatment or counseling including: group psychotherapy, encounter, group-play therapy, and psychodrama.
   - Chemotherapy including tranquilizers, antidepressants, anticonvulsants, sedatives, etc.
   - Social system psychotherapy involving "contacts and relationships between family members and non-family members to include in the psychotherapeutic situation any number of persons who are related by either kinship, friendship, functional relationship, or community residence."[1]

In addition to the foregoing types of ambulatory care, there is a special format that is used for psychiatric work in court settings. Court clinics were originally mandated to provide psychiatric services to courts and diagnostic and treatment services to offenders before courts. This broad charge has allowed for an everdeveloping scope of services over the past 16 years. Thus, the services now provided by court clinics include the following:

- Mental examinations, as indicated by law, of individuals referred by the court.
- Evaluations of offenders upon request of the court as an aid in planning for their rehabilitation.
- Consultation to judges and probation officers in legal-psychiatry matters.
- Psychiatric treatment and other mental health services to offenders and their families referred by the court.
- Sharing professional knowledge in probation-clinical conferences for increasing acumen in the difficult tasks of managing and helping offenders.
- Consultation and evaluation services, when requested, to court-sponsored programs and facilities of offender rehabilitation.
- Keeping functional case statistics and providing reports and evaluations to the court about the clinic's functioning relative to the court's needs.
- Maintaining working relationships with mental health and other community agencies, facilities, and programs involved in the welfare of offenders.

Staffing Patterns

Differing skill levels are required for the various ambulatory services described previously. Some services require highly trained specialists, others can be performed adequately by persons with only a basic training. As these distinctions have become incorporated within job functions, several staffing

[1] Patterson, E. Social System Psychotherapy. *Mental Health Digest*, Vol. 5, No. 11, November 1973. P. 49.

trends have become apparent. Such highly trained personnel as psychiatrists, psychologists, social workers, psychiatric nurses, and occupational therapists are taking on more consultative responsibilities in addition to treatment and community liaison functions. This trend is consistent with the thinking of some that staff should not provide consultation and education unless they also have clinical responsibilities.

Another staffing trend is the use of paraprofessionals in treatment roles and as community development specialists. A related trend is the use of volunteers for primary prevention and direct treatment services with staff specialists in a backup capacity. Agencies employing paraprofessionals and volunteers have found that local neighborhood people are most effective and should be recruited to work within their own social network. This staffing pattern obviously necessitates special care in the use of confidential information. Nevertheless, the considerable talent available in local neighborhoods represents an untapped resource. For example, in the Taunton Area and in the Blackstone Valley Area, one-third to one-half of the many mental health volunteers are professionals in other fields.

An additional source of manpower for mental health centers is their former clients. Such persons, traditionally underutilized despite their unique sensitivity and awareness of key concerns, could be trained to perform a range of important functions, e.g. home visiting, orientation to treatment, and assessment procedures.

As a variety of caregiving personnel and volunteer teams assume broader treatment functions, psychiatrists are being freed to specialize in more complex therapeutic roles as well as the supervision of chemotherapy. Administrative tasks similarly are being performed by a variety of disciplines and medical skills are being concentrated in those areas of care where it is essential.

Staff should be deployed in a variety of ways to insure physical and psychological accessibility to persons in need. Thus, in all clinical settings, there should be an appointment system, evening hours on a regular basis, a walk-in service for persons unable to schedule prior appointments, and a 24-hour telephone service. Specific patterns for effectively deploying staff are described best in relation to whether the catchment area is urban, suburban, or rural in nature. The following examples of existing Massachusetts programs are presented as points of reference and not as ideal models to be blindly emulated.

Urban

The Cambridge-Somerville Mental Health and Retardation Center combines centralized services at Cambridge Hospital, Cambridge Guidance Center, and Somerville Guidance Center with those which are increasingly neighborhood-based. Mental health services at the neighborhood level are integrated in neighborhood health centers, multi-service centers, and with such other caregiving agencies as schools, settlement houses, etc.

The population base for neighborhood programs is 15,000. When fully operational, staff deployed at the neighborhood level will include two paraprofessionals, one psychiatric nurse, a one-half time social worker, a one-third time psychologist, a one-fifth time psychology student, a one-third time psychiatric resident, and a one-quarter time psychiatrist. Although these personnel will operate within comprehensive health and human services centers, nonmental health staff of the centers also will provide appropriate mental health services. As this staffing pattern evolves, ambulatory teams also will be based in central facilities with each team covering two neighborhoods of 15,000 people each. The staffing pattern for these centralized subcatchment area adult services should include one social worker, a one-third time nurse, a mental health worker, a psychiatric resident, one psychologist, and various students. A similar pattern would be required for children's services.

All staff would function as generalists as well as specialists. For example, the psychologist would be responsible for the overall care of a number of clients in addition to doing psychological testing of other clients when necessary. Paraprofessionals employ generic mental health skills and perform a range of functions including psycho-social evaluations, individual, group and family therapy, and consultation and education. Naturally, the more complex functions are performed only after training and experience in the human services field. Collaboration and consultation with a wide variety of other caregivers are stressed, including youth workers, social welfare workers, teachers, etc. Students and volunteers in a variety of disciplines also are used to provide services.

Some staff are based centrally to serve people who prefer the anonymity of that setting and who do not have a transportation problem. Staff with special capabilities also tend to operate from the central base. The ambulatory program in this model is linked to the inpatient program with the principal therapist often continuing in that role even when the client is admitted for inpatient care. On some occasions staff in the inpatient program provide aftercare when clients are transferred to the ambulatory setting.

Suburban

An example of a suburban ambulatory program is that conducted in Danvers by Liberty Street Associates, a private, proprietary corporation which provides services through contracts with various

human services agencies and directly to the public as well. Although it does not serve an entire catchment area, this ambulatory program model is novel in terms of its sponsorship and treatment approach. Although only the ambulatory service is described here, Liberty Street Associates offers a variety of services which collectively comprise a total delivery system. Two administrative staff operate the entire program, and additional support is provided by secretaries and accounting staff.

At present, a variety of ambulatory treatment modalities are offered by the equivalent of 12 full-time highly trained staff representing a variety of behavioral sciences. A staff approximately double this size would be needed to provide complete ambulatory service to a population of 100,000 people. Since personnel are selected on the basis of talent and ability rather than discipline and credentials, all are paid at the same rate by Liberty Street Associates.

The treatment emphasis is on the client's family and social network, an approach with both advantages and disadvantages. Social network therapy takes considerably more time than individual counseling, but the staff considers this modality much more effective and long-lasting in its benefits since staff is intensively involved with client and social network change. Prevention is, of course, also a major benefit.

Personnel are on call 24 hours per day, seven days a week. Agency facilities are open all day and in the evening. New clients are not arbitrarily assigned to staff. Instead, following the evaluation process, the client is matched with the therapist most able to meet his/her unique needs. Staff are allowed to use a combination of modalities and services in assisting individuals and their families and are continually being trained in various special techniques. Among the treatment options offered by Liberty Street Associates to ambulatory clients are a Day School program for children of a family in therapy and a Life Skills program which is recommended in conjunction with active counseling. There is also an Activities program operated by three staff for children in groups of six to eight.

Small City, Town, Village

An ambulatory program model relevant to smaller geographic settings is that provided in the Taunton area. It emphasizes social network therapy by operating through decentralized neighborhood problem-solving or human services centers serving self-defined neighborhoods of 10,000 people or less. Although some may contend that this model is only applicable to rural areas, it is worth noting that even urban or suburban settings often can be demarcated in terms of neighborhood locales of 10,000 people.

The staffing pattern utilized in one of the neighborhood-based human services centers serving 10,000 people is one full-time director, who is often a paraprofessional, and one professional community nurse. Ten volunteer counseling teams are also used with four volunteers on each team. Up to 30 additional volunteers participate in various capacities. Approximately 80-100 volunteers, thus, are used in each center program, each person working an average of three hours per week not including training and other meetings. This staffing component should be multiplied by approximately 10 to staff an area of 100,000 people.

In addition, there are clinical staff based in the Taunton Area Office. At present, these include one psychiatrist, one psychologist, and one nurse. Ideally, area staff should include two psychiatrists, two-to-three senior psychologists, two-to-three junior psychologists, and two community nurses. Area Office staff also includes one area director, one associate area director, three research assistants, and one to two secretaries, all of whom are heavily involved in conducting training programs for area staff and volunteers. Most of the area clinical staff work out of the neighborhood centers with specialized staff based in the Central Office to serve the entire area. The very large volunteer program now in operation requires that training be an active and continuous process.

Many of the services are being provided by paraprofessionals and volunteer staff with professional staff assuming consultative and specialized treatment roles including medical supervision when necessary. It is estimated that 50 percent of all ambulatory services being provided in this area are given by trained volunteer staff.

Court Clinics

The basic staff for each court clinic consists of a psychiatrist, social worker, psychologist, and a secretary. This model is expanded when necessary and feasible to include other appropriate personnel, such as social work students, psychiatric residents, and community health nurses. The programs vary in size from the smallest clinic consisting of a psychiatrist to the largest which includes four psychiatrists, nine psychiatric residents (part time), six social workers and four social work students, two psychologists, and two secretaries.

Facilities

Facilities of both a centralized and decentralized type are needed for ambulatory services. Centralized settings are highly visible to clients and funding sources. They are attractive to clients shunning service in their own neighborhood. When linked to a general hospital, centralized facilities facilitate referrals and third-party reimbursements.

Decentralized services are becoming increasingly common due to their accessibility, e.g. Boston State Hospital's Neighborhood Service Center. The sharing of common facilities with other human services which practice within neighborhood settings has followed three models:[1] (a) psychiatrist as consultant, e.g. Martin Luther King, Jr. Neighborhood Health Center in the Bronx, New York; (b) mental health service operating independently within a neighborhood health center, e.g. Westside Neighborhood Health Center, Denver, Colorado; and (c) mental health service operating as an integral part of the comprehensive health center, e.g. Boston's Roxbury Neighborhood Health Center and Jamaica Plain Family Life Center. Mobile units can operate out of central or satellite facilities, particularly for home visiting programs.

Costs

The staffing patterns described previously must be costed out both for staff salaries and fringe benefits, which approximate 80 percent of the total budget, and for other expenses. Additionally, staff assigned to other units may also participate in ambulatory care.

Urban

The Ambulatory Team of the Cambridge-Somerville Mental Health Center is responsible for providing services at the neighborhood level and, therefore, is stationed in various community settings rather than in a central facility. Each team serves a population of about 15,000 people; approximately six such teams are needed to serve a population of 100,000. Such staff and their average annual salaries are indicated in Table 2-5.

In addition to this basic staff, three ambulatory teams are based in a central facility, i.e. Cambridge Hospital, and linked to the neighborhood teams. Each centrally based team would be aligned with two neighborhood teams; together they provide the totality of ambulatory services to their combined populations of 30,000. In an area of 100,000 people, three centralized teams would be comprised of the staff as indicated in Table 2-6.

The cost per year for six neighborhood teams at $41,900 each totals $251,400; three central teams at $85,400 each totals $256,200 for a grand total of $507,600. It should be noted that the Cambridge-Somerville Area does not presently have all of these staff resources in place, but this model is being phased in over time.

The previously mentioned costs do not include staff to provide children's services for which it can be estimated that a similar staffing pattern would be required in an area of 100,000 people. These costs also do not include funds for overall administration of the mental health center, for administrative support staff, or for the renting of neighborhood facilities—all requisite expenses in a comprehensive program. In sum, approximately $1,015,000 is required for direct service staff to provide ambulatory services to adults and children with additional funds needed for administration and overhead costs, estimated at 20 percent to 30 percent of direct personnel costs. This amount does not include adult court clinic services and preschool and retardation programs.

Suburban

Costs for staffing the Liberty Street Associates proprietary model are based upon the fee-for-service standard. Staff are reimbursed on an hourly basis since this is considered more efficient. The average staff person has approximately 25 to 30 therapy hours per week. Since this model is proprietary and subsidies are unavailable, no sliding fee scale is used. A charge of $35 per hour is made to all clients. Reimbursement to therapists is $17.50 per hour with an additional amount going for overhead including administrative salaries, facilities, maintenance, and support services such as accounting, clerical, etc. The charge for group therapy is $10 per hour. The therapist is paid $21 per hour for work with groups. If there is a co-therapist, he/she is paid somewhat less; often, this second person is a staff trainee.

The Activities program for children in groups of six to eight is conducted by three staff. The cost is $10 per hour per child. Average staff salary is $10,000 per year. Specially trained staff are used for this particular modality, and large numbers of children can be served.

In order to estimate the annual cost of providing comprehensive ambulatory services to the entire Danvers-Salem Area using the proprietary model, an effort was made to document the volume of service being provided by a variety of private and public sources. Liberty Street Associates estimated that a typical staff person delivers approximately 25 treatment hours per week at a charge of $35 per hour. The equivalent of 12 full-time staff provide this volume of ambulatory services, and the estimated annual fee to Liberty Street Associates would be $504,000. Direct ambulatory services also are provided by state personnel located at: Danvers State Hospital, the North Shore Child Guidance Clinic in Salem, the Court Clinic, and the Community Mental Health Resources Development Unit. The last is a new service operation directly responsible to the Danvers-Salem Area Board. The equivalent of

[1] Lee B. Macht. Neighborhood Psychiatry. *Psychiatric Annals*, 1974 (September), 4, 43-58.

Table 2-5. Cambridge-Somerville Ambulatory Team And Salaries: Neighborhood-Based

Staff	Full-Time Salary	Actual Salary
2 Paraprofessionals	$ 7,200	$14,400
1 Nurse	12,000	12,000
1 Social Worker (one-half time)	11,000	5,500
1 Psychiatrist (one-quarter time)	24,000	6,000
1 Psychiatric Resident (one-third time)	12,000	4,000
	Total	$41,900

Table 2-6. Cambridge-Somerville Ambulatory Team And Salaries: Centrally Based

Staff	Full-Time Salary	Actual Salary
1 Psychiatrist	$28,000	$28,000
1 Psychiatric Resident	12,000	12,000
1 Psychologist	16,000	16,000
1 Social Worker	11,000	11,000
1 Nurse (one-third time)	12,000	4,000
1 Mental Health Worker	7,200	7,200
1 Secretary	7,200	7,200
	Total	$85,400

11 additional full-time ambulatory staff are employed by these various auspices, generating an additional 14,892 treatment units per year. If these service units were purchased from a proprietary source at $35 per hour, another $521,220 would be required. Salem Hospital's Mental Health Unit is also a significant provider of ambulatory care; in Fiscal Year 1974, it provided 4,949 units of service. When calculated at the rate of $35 per hour, the volume would cost $173,215. Added to the $504,000 of service generated by Liberty Street Associates, the total estimated annual cost including salaries, support, and facilities for the area would be $1,198,435.

Small City, Town, Village

Costs associated with the ambulatory program conducted in the Taunton Area are based on a network of decentralized facilities supplemented by staff based in a central Area Office. Staff in each of 10 decentralized facilities include a director who can be a mental health worker, nurse, social worker, etc., an assistant and a clerk. This decentralized component requires 30 paid personnel. The large number of participating volunteers are not paid. Staff members based centrally in the Area Office include two psychiatrists, two psychologists (Ph.D.), four persons with master's degrees in the behavioral sciences, four nurses, three clerks, three technicians performing a variety of tasks, and two additional direct treatment staff members. This centralized component requires 20 paid personnel. Costs for both the centralized and decentralized components are allocated as follows:

Table 2-7. Taunton Area Ambulatory Program Annual Costs

Expense	Unit Amount	Cost
Personnel (50)	$12,000	$600,000
Travel	600 (average for each of 50 personnel)	30,000
Rent, Heat, Light		
Centers (10)	4,000	40,000
Area Office	7,200	7,200
Telephone		
Centers (10)	2,400	24,000
Area Office	2,000	2,000
Equipment and Supplies		
Centers (10)	1,600	16,000
Area Office	10,000	10,000
Miscellaneous		10,000
	Total	$739,200

Income Sources

Ambulatory services frequently are reimbursable from third-party sources, and a large number of Commonwealth residents now have some type of private health insurance providing at least limited coverage for ambulatory service. This coverage will increase significantly on January 1, 1976 as a result of recent state legislation[1] mandating that private hospital and surgical insurance carriers offer such benefits to their subscribers. Up to $500 in outpatient services will be covered over a 12-month period of time when provided by a comprehensive health service organization, a licensed or accredited hospital, a Department of Mental Health-approved facility, or a psychiatrist or licensed psychologist. The Group Insurance Commission of the Commonwealth, which negotiates health insurance for the large number of state employees and their dependents, is in a key position to expand ambulatory mental health service coverage for many persons.

A variety of federal and state programs already provide ambulatory coverage. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a broad health insurance program for active, retired, or deceased members of the uniformed services and their dependents. Benefits are available for ambulatory services for persons covered by this plan. The Veterans Administration, while providing the majority of such care in its own facilities, nationwide spends 25 percent of its ambulatory service resources by reimbursing for care rendered in non-Veterans Administration facilities.[2]

The state-administered Medicaid program in March 1974 gained approval from the Massachusetts Rate Setting Commission to reimburse freestanding mental health centers for provision of ambulatory services. Similar arrangements were negotiated in spring 1975 for Medicaid reimbursement to eligible family and children's service agencies. This is now a significant reimbursement source for eligible providers serving Medicaid clientele.

All of these reimbursement programs are categorical in nature. Specific groups and individuals have varying coverage which complicates the process of billing and receiving payment. Generally, persons who are on public assistance of one type or another have some type of coverage which guarantees them service. This also gives them the flexibility to shop for a provider of their own choice. Such persons primarily are dependent children under 21 and elderly over 65. The large number of low- and middle-income adults not covered by private health insurance have the least opportunity to get services with third-party coverage.

An urban ambulatory center affiliated with a community general hospital is able to bill various third-party sources including private insurance companies, Medicare, and Medicaid. It also can charge client fees. On collecting such fees, the Center is

[1] Chapter 1174 of the Acts of 1973.

[2] National Institute of Mental Health. Multiple Source Funding and Management of Community Mental Health Facilities. Department of Health, Education, and Welfare Publication No. (HSM) 73-9055. P. 22.

able to retain them under a contractual arrangement to offset operating costs without the fees reverting to the Commonwealth's General Fund. Such a center retains much more money from third-party payments than do the "partnership" clinics operated by local mental health associations and the Department of Mental Health. Despite recently negotiated agreements regarding Medicaid fees, some partnership clinics retain so little new money that it is not economical to establish requisite billing systems.

Income sources for a proprietary organization like Liberty Street Associates are as follows: 40 percent from private insurance companies, 31 percent from public agencies, and 29 percent from client fees. Income from public agencies includes contracts written with schools for consultation and with state agencies other than the Department of Mental Health for purchase of services. Contracts with the Department are possible but have not been executed to date.

In the Taunton Area model, the vast majority of operating income is derived from the Department of Mental Health with small amounts available from grants, municipalities, and miscellaneous sources. Each of the neighborhood centers had been incorporated as a private, nonprofit agency so that it can raise funds; but no billing is being done yet.

The clientele served by court clinics differs greatly from that of a traditional social work agency in that court clinic clients often are economically and socially deprived, frequently rejected, and/or unmotivated. Since psychiatric services in the court system are mandated and involuntary, the income for supporting these services obviously must come from public sources.

Service 4: Day and Evening Treatment

Day and evening treatment has been highlighted by the 1965 federal community mental health center legislation and regulations as essential. It represents a distinct anchor point in the community mental health program's spectrum of alternatives to hospitalization. Numerous studies over the past decade throughout the United States have demonstrated conclusively that this treatment modality is equal to, or superior to, acute psychiatric hospitalization for a broad cross-section of significantly disturbed and disorganized persons who traditionally have been treated only in inpatient settings. The clinical findings apply to day and evening care provided prior to hospitalization as well as to treatment for those who have had brief inpatient stays. There is no doubt by now that the day treatment center, as an intensive treatment setting, offers meaningful alternatives to hospitalization for acute or subacute psychiatric problems.

This emphasis represents, however, only one level of the day treatment center's program and organization. It is important to distinguish the other use of this modality in caring for clients requiring longer term treatment and rehabilitation. This second group includes many for whom open-ended, long-term resocialization and rehabilitation are necessary; for them, day and evening care also are essential services.

Day and evening treatment as a basic element in a comprehensive community mental health program, thus, involves a spectrum of program organization, treatment modalities, and potential consumers. Since all catchment areas contain significant numbers of present or potential users of the full spectrum of day and evening care, it is appropriate that a variety of models and service designs will arise to meet these needs. It is striking, however, that at the present time this essential service is significantly underutilized in most of the state's catchment areas. It is promising to note, though, that in recent years day and evening treatment has been one of the fastest growing service elements in expanding community programs.

There is sufficient experience to indicate that the full spectrum of day and evening care probably cannot be delivered well in one program, and that at least two separate programs serving two distinct clusters of patients are necessary in each catchment area. The programs can be referred to as Level I (intensive or acute) and Level II (long-term or chronic) but the practical realities are the same in any case.

In current practice, most day treatment centers offer services only during the usual business hours of 9:00 a.m. to 5:00 p.m. Financial expediency and staff preferences often weigh significantly in such decisions. Patient needs, however, indicate that in many instances treatment is just as essential in the evening hours, from late afternoon to 9:00 p.m. or 10:00 p.m. This schedule may be particularly relevant for those persons still able to maintain themselves in occupational settings during the day. Evening treatment centers also could provide a base for evening and night-time emergency services. Some day treatment centers have experimented with opening their program one or two days a week at noon, instead of earlier in the morning, and extending service into the mid-evening hours.

Some new and even established day and evening treatment centers report significant problems in finding and retaining clients. An inordinate part of the staff's energy is consumed in maintaining an adequate stream of referrals and preventing inappropriate dropouts. It is probably fair to speculate that in these instances, the cause is related to lingering ambivalence about this basic service as a legitimate alternative to 24-hour residential care. The problem may also be related to the fact that these programs often develop and remain relatively isolated, never truly integrated into the community network of mental health services.

Organizational Auspices

In order to avoid some of the previously cited problems, day treatment centers should not be free-standing. They must be formally affiliated, integral elements of the community mental health network. This structural arrangement can be pursued under a variety of public or private auspices; as components of, or affiliated with, community mental health centers, general hospitals, or mental hospitals.

While the same programmatic functions can be provided in a wide variety of physical settings, day and evening treatment centers located directly in a general or mental hospital experience certain problems. This in no way reflects adversely on the quality of service offered by these institutions; rather, it emphasizes the principle that day and evening treatment centers operate best in an ambiance conveying normalization rather than illness. If such programs are to be located in a general hospital, rapidly rising costs and space constraints make it essential that they have separate budget centers to determine true costs. It should be noted that a day or evening treatment program can be administered very well as part of a hospital-based mental health system without the day center being located on the immediate premises of the hospital.

Program Content

The size of any day and evening center will vary in

accordance with the catchment area's population, density, transportation patterns, etc. Based on average daily attendance, the minimum to maximum number of persons served by any program unit within the center can range broadly from 10 to 70 enrollees. When the daily census exceeds 40, additional treatment units or satellites with commensurate staff increases generally are indicated. Often, a continuum of programs develops on the basis of client performance levels and/or their special service needs. In the most general sense, day and evening treatment centers fulfill the following purposes:

Level I

- An alternative to 24-hour residential care for persons experiencing acute crises.
- A transitional program for those leaving 24-hour care.
- A program for intermediate term rehabilitation of persons with long-term mental illness-related social and vocational deficits.

Level II

- A program for persons so seriously impaired that prolonged institutional care would be needed except for the support and services of the day and evening treatment center.

The treatment programs designed for any of these purposes must include resocialization and rehabilitation since they are vital to facilitate community reentry and adjustment. The terms *re*socialization and *re*habilitation imply restitution approximately to earlier levels of functioning. However, many participants in day and evening treatment centers (particularly at Level II) have never acquired necessary social and vocational skills; they must now be taught basic, rudimentary capabilities. These skills and capabilities can be learned only over extended periods of time; and Level II participants, therefore, must be provided long-term care. The possibility of Level II programs degenerating into "back wards" in the community must be guarded against. By housing Level I and Level II programs in the same physical facility, this danger is reduced, costs are reduced, and the availability of specialized staff is increased.

The core of a day or evening treatment program is based in a therapeutic community which permits an individual to find his/her own maximum level within a self-actualizing group. Such a quasi-community shares activities and responsibilities for its members as individuals and as a community. Meaningful decision-making is fostered and encouraged. Out of this approach and atmosphere develop increased self-confidence, self-responsibility, and self-correcting experiences fostering both individual growth and group identity.

If the goals of a day and evening treatment center are to be achieved, its services should include a variety of large and small group activities, scheduled and informal program activities, individual, family, and group therapy, and creative and expressive therapy sessions (music, drama, art, body movement, etc.). Group activities can include, but should not be limited to, discussion groups on such topics as: coping with problems in daily living, establishing personal hygiene and nutrition habits, and being aware of current events. Educational instruction groups may focus on poetry, photography, cooking, public speaking, crafts activities, sewing, occupational therapy, newspaper writing (completely uncensored), sports, etc. The program content should be varied enough to appeal to at least the vast majority of individuals. Cultural awareness groups are critical in heterogeneous communities. Thus, relevant program content should be available to meet the specific goals set for the person.

Provisions should be made for patient government in the center so that patients may play an active role in planning a large portion of their daily program activities. Community officers can be elected monthly. Activities may need to be started by staff or volunteers, with the patients brought into them by the leadership and enthusiasm of these individuals. However, when activities are spontaneously initiated by patients, they should be encouraged and appropriately staffed by the center personnel.

In addition to activity therapies, the center's treatment programs also should include when appropriate intensive psychotherapy, goal-focused counseling, and marital and/or family therapy. The specific therapeutic-oriented approaches utilized by a center inevitably will depend upon program design, the skills and treatment philosophies of its staff, and the availability of specialized personnel. Thus, treatment approaches at some centers also may include behavior therapy, gestalt techniques, etc. Regardless of the specific elements in any center, medical diagnosis and prescriptional medication by a qualified physician should be included as a basic part of the treatment program.

The rehabilitation component of the program should be multi-dimensional and include in its objectives helping persons achieve maximal independent living. Whenever possible, full-time employment should be considered a goal. Where appropriate and desired, full resumption of a relevant role in the home might be an appropriate end goal. When independent functioning cannot be achieved, placements in the community on voluntary tasks should be considered. These latter placements could be used either as terminal or as work-conditioning activities, depending on the goals established for each person. The center's vocational rehabilitation efforts can be facilitated through active linkages with state agencies such as the Massachusetts Rehabilitation Commission and the Division of Employment

Security. Sheltered workshops emphasizing work skills and habits leading to regular outside employment can be integrated or affiliated components of a day treatment center.

A number of centers have found that by developing an Alumni Club, an important open-ended link is provided many patients and their families for whom the center is the only or major social contact. This group, in turn, can be quite helpful and, in turn, is helped by working with newcomers to the center.

Policies and Procedures

The day and/or evening treatment center's goal of client self-reliance through active therapy can best be achieved when specific policies and procedures guide the center's activities. Necessary guidelines include at least the following:

1. A statement of objectives and personnel responsibility.
2. A written admission policy describing the criteria for acceptance into the program; the criteria should be as broad as possible and inclusionary rather than exclusionary. Important criteria include:[1]
   - Willingness and ability to accept a therapeutic contract.
   - Willingness and physical ability to attend and participate in the program activities.
   - Status as an outpatient or an inpatient in the final stages of hospitalization.
   - Residency within a practical commuting distance.
   - Self-medication status (this is desirable but should not exclude alternate methods of receiving medication).
3. A written intake policy which includes procedures for multi-staff assessment of each individual and review by a designated intake team of each patient's problems and treatment plans. This review should include participation by a psychiatrist, even if only on a consulting basis.
4. An active treatment plan for each patient based on an assessment of the individual's functional problems and specification of treatment goals relevant to each problem. The treatment plan should include a schedule of the individual's program activities, recommended frequency of attendance, and anticipated length of treatment.
5. A requirement that each individual enter into an explicit, negotiated agreement to participate in program activities as specified in his/her treatment plan.
6. A procedure for periodic indepth review of each patient's goals and treatment plan. This indepth review should be done within 20 attendance days after admission, and at least once every 40 (60 in Level II) attendance days thereafter. This review should involve the "case manager" or "primary therapist" and at least two other staff members. The team members and each patient, where appropriate, must review any substantial changes in patient goals and treatment plans.
7. A weekly staff meeting at which patient problems, group issues, and activity plans can be individually reviewed.
8. A policy that relatives or friends supporting the patient be involved regularly, or at appropriate intervals, in program activities and plans.
9. Written procedures for referral for collaborative treatment or discharge and follow-up.
10. Written procedures for referral of patients to other community facilities for specialized evaluation and treatment services not provided by the day or evening center.
11. Formal recordkeeping is recommended to facilitate referrals.

Numerous advantages are evident in the policy of an explicit maximum length of stay for patients in the Level I program. Many centers have fixed this limit at six months, with procedures for exceptions for an additional three months. The average length of patient stay in a number of programs is approximately 10 to 12 weeks. The clinical issue which is particularly central for those persons who have had an institutional experience is their expectation of perpetual passivity and dependency; the maximum length-of-stay "contract" keeps this issue in the forefront of the therapeutic program.

No maximum time limit need be set in the Level II program. These programs are designed to keep people for as long as they might need to be in them. This population tends to be fairly stable but chronic, and the program must tolerate a great deal more dependency from its participants.

When the wide-ranging responsibilities and services of day and evening treatment programs are placed in perspective, it is clear that they cannot function in isolation from the human services system if their goals are to be achieved. Thus, the center must have explicit, formal, and direct administrative links to other facilities such as hospital inpatient services, hospital emergency services, community residences, social clubs, community workshops, and other community life-support agencies. When all relevant treatment facilities come under the direct authority of the Area Director, administratively or contractually, continuity of care and accessibility should be assured.

[1] *The Day Treatment Center Organization and Therapeutic Programming.* Program Guide. Veteran's Administration, Washington, D.C., December 9, 1974. G-10 M-2, Part X, P. 3-1.

Staffing Patterns

In hiring staff for a day and evening treatment center, consideration should be given not only to an individual's qualifications but also to his/her interests, abilities, and motivation to function in an innovative treatment and rehabilitation setting. Experience in day or evening treatment centers has shown that many personnel without formal graduate training are highly skillful in assisting patients. Experience also has shown, however, that day and evening centers should employ skilled professional staff from a variety of disciplines. There are considerable advantages to employing capable residents of the neighborhood and larger community as mental health associates. Such persons not only make appropriate contributions to the program, but they also facilitate linkage with the community.

Staffing patterns should vary with the level of intensity of the treatment services. Therefore, it is appropriate to expect that a Level II program would not require that all staff have extensive formal mental health training. Natural interpersonal skills and talents with ability to use appropriate supervision and capacity for long-term stable commitments are the essential requirements for staff in this type of center. However, skilled staff should participate in diagnostic workups, in determining the appropriate components of the treatment program, and in the periodic review of the treatment program.

The following staffing pattern identifies personnel that various federal and state agencies consider appropriate. The highly specific format is not intended to imply that alternative approaches to staffing such programs should not be considered. Nevertheless, it should be kept in mind that future funding of these programs will depend on meeting accreditation standards which emphasize staffing patterns and capability to perform stated program functions.

It is unnecessary to require that a physician serve as program director. Such a professional should be considered for the job of program director only if he/she has the skills and interests to work within a rehabilitation program model. The basic principle must be that the most qualified mental health professional regardless of discipline will be chosen as the program director. Similarly, the salary of the director should be commensurate with the scope of his/her overall responsibilities rather than being tied to his/her professional degree. This salary scale should be flexible enough to compensate an individual according to the scope, breadth, and complexity of the program being administered. Roles and personnel include the following:

Program Director

Qualifications: A mental health professional with at least a master's degree and a minimum of two to five years of clinical and administrative experience which may include full-time graduate or postgraduate training, experience and responsibility; one year of experience must be in a therapeutic milieu program. If an individual does not meet the professional degree requirements, at least fuve years of progressively responsible administrative and clinical experience should be considered as a reasonable substitute. The mental health professional in charge of the day or evening treatment center program should be designated: Director, Day (or Evening) Treatment Center; when program size requires, another individual may be designated: Assistant Director, Day (or Evening) Treatment Center.

Duties: The directorship of a day and evening treatment center is considered a full-time position. The director should have complete professional responsibility for all clinical and administrative functions within the center. He/she should have responsibility for the hiring of staff, their work assignments, arranging for supervision, and subsequent evaluation. The director of the day or evening treatment center could be administratively responsible to the Area Director, or to such person as is designated by the Director.

Psychiatrist (Part-time)

Qualifications: An M.D. registered in Massachusetts and who has completed at least three years of accredited psychiatric residency.

Duties: Responsible for the medical/psychiatric assessment and medical treatment of patients, and *consultation* with staff on program objectives and activities. Under most conditions, it is expected that the psychiatrist would be a part-time staff member; however, the position could be a full-time one when the program has reached sufficient size, has complex medical needs, and the psychiatrist is interested in working within a day treatment model.

Psychologist: A licensed psychologist with relevant clinical skills.

Psychiatric Social Worker: A graduate from an accredited School of Social Work with at least one year of relevant clinical experience.

Occupational, Rehabilitation, or Activities Therapist: A bachelor's degree graduate from an accredited college with one year of relevant clinical experience.

Psychiatric Nurse: A master's degree graduate in Psychiatric Nursing with at least one year of relevant clinical experience, or an R.N. with at least three years of appropriate psychiatric experience. Licensed Practical Nurses or Psychiatric Technicians also should be included.

The following staff constitute the core professional personnel, and they should work full time: program director, social worker, nurse, and occupational or

other therapist. Other personnel skills relevant to the services of a day and evening treatment center are those of music, art, and drama therapists. As with other mental health services, former patients can make a unique contribution to a day and evening treatment center's work. They should be hired when possible for appropriate positions. Day and evening treatment centers also should be encouraged to devise programs for students and volunteers. The former are readily available at local colleges and universities having mental health-related curricula with practicum assignments. It is imperative, however, that adequate supervision and consultation be provided for students and volunteers. A staff to patient ratio of 1:5 or 1:6 based on average daily attendance and level and intensity of therapeutic program would provide adequate treatment resources. Additional staff would be required for such support functions as secretarial, clerical, bookkeeping, and maintenance.

Several centers in various parts of the state should be selected as model training facilities for newly hired, inexperienced professional and paraprofessional personnel. The training programs offered by these centers should deal with both the clinical and administrative responsibilities involved in operating a day and evening treatment facility.

Facilities

Location: Day and evening treatment centers may show considerable variation in the location of their physical plant. They can be located within a general or state hospital building or be part of a community mental health center. Some centers are located in a separate building on the hospital grounds; others are located from several blocks to many miles away from the hospital. Simple, flexible program space is the most important determinant. Distance from the hospital setting will strengthen the social rehabilitation goals of the center and give patients a greater sense of autonomy in achieving their therapeutic objectives. It is strongly recommended that the facility be located in the center of its community so that both psychological and geographical accessibility are facilitated.

Transportation: Though particularly pertinent to rural centers, the issue of transportation also must be addressed by urban centers and especially by urban-evening treatment centers. Ease of access to the center for both the acutely disturbed patient and the ofttimes less-motivated chronic patient becomes increasingly critical when daily or near-daily attendance is required. The day or evening center must address this need and federal resources are available for developing transportation services, e.g. Department of Transportation, Elderly Affairs, and Developmental Disabilities funds may be sought for this purpose. Local revenue sharing funds also have been tapped in some communities for the one-time expense of purchasing vehicles.

Space: Space allotments for needed facilities vary in direct proportion to the program's size. The following suggestions for space allocation are based on standards considered to be in the range of very adequate to ideal. The square footage and variety of rooms may not be attainable for all programs. In general, a light, airy, homey atmosphere is desirable with a minimum of 2,500 square feet. Beyond the 2,500 square feet minimum for 10-15 patients, it is recommended that an additional 120 square feet of space per patient be provided. The space should be arranged so as to permit the varied functions of the center to occur as effectively as possible. Depending upon local costs and available funds, any or all of the following could be included in the center:

- A *living room* large enough to allow for non-institutional groupings of attractive, comfortable home-like furniture. This room would be used for formal and informal gatherings, primarily of a verbal nature.
- An *activity room* corresponding to a home rumpus room or recreation room would be used for active group gatherings. It would normally contain billiard and ping-pong tables; folding tables and chairs and sliding accordion doors increase the flexibility of this space.
- A *kitchen* is important for promoting social and homemaker skills and serves educational purposes as well. It should be large enough to accommodate groups for classes in such activities as economy shopping, personal meal preparation, and the preparation of group meals. Particularly for older women and more chronic patients, this area can be the focal point of their rehabilitative program.
- *Creative skills* activity areas for occupational and manual arts therapies should be near appropriate electrical outlets and water, sound deadened, and located well away from other verbal activity areas. Open space for body movement, drama, etc. as well as a closed, soundproofed room for music are very useful.
- *Office space* should include an adequate work area for all staff, with the ideal being one office per full-time staff member. Sufficient supplemental space should be allotted for clerical functions as well as for students and consultants.
- *Group rooms* will vary in number and size according to the philosophy of the program. These rooms can accommodate such activities as group therapy, group discussions, family groups, committee meetings, staff meetings, etc.
- A *physical activity area* is used for larger motor activities and minor gymnastic programs (refer to previously mentioned creative skills activity areas).

- A *sheltered workshop*, no matter how modest, is suggested for inclusion within larger facilities including specific space for work-potential assessment.

Costs

The costs of delivering human services depend largely on staff-salary expenditures. This salary account may vary greatly, depending on the professional disciplines from which personnel are drawn, their length of experience, and other such factors. As was indicated previously, the cluster of skills needed to operate day and evening treatment centers can be drawn from a wide-ranging personnel pool. The following positions and disciplines are usually associated with this type of program, either on a full- or part-time basis: program administrator; clinical psychologist; psychiatric social worker; psychiatric nurse; psychiatrist; occupational, recreational, or activities therapist; special counselors or therapists and aides; secretaries and clerks; and maintenance personnel.

The total costs for day and evening treatment centers, in general, will be based on a program serving an average daily census of 20 to 30 patients. This average is based on a recent Department of Mental Health projection that, in the near future, 900 to 1,000 persons in the state should be served by such programs. Budgets for these programs now are being forwarded to the Department of Mental Health and will be available for reference in determining specific expenses. It is anticipated that the average cost per patient will be between $25 to $35 per day, based on a program serving 20 to 30 patients.

Income Sources

A task force, composed of members of the Departments of Mental Health and Public Welfare, is at present negotiating with the Rate Setting Commission for a per diem rate of reimbursement. The established rate will be in effect for one year or until such time that the Rate Setting Commission can establish an individual rate for each facility. This rate will be used to gain reimbursement for the cost of services rendered patients covered by Medicaid and Workmen's Compensation. Other third-party sources include Medicare, commercial insurance carriers, patient fees, and local governmental and philanthropic support. All of these reimbursement sources are relevant, but fiscal viability is predicated on the assumption that the Department of Mental Health will make initial startup funds available to provide the services which will be billed for later. Again, in this instance, it is important that the billing be done by a corporate entity other than the Department of Mental Health so that receipts can be retained for future program use. This is the most effective way to insure some type of absolute resource growth and stability under foreseeable fiscal circumstances.

Service 5: Vocational Rehabilitation

Great progress has been made in recognizing the importance of the patient's family and network of social contacts and supports. Treatment in the community makes possible an alliance between the patient, mental health professionals, and the patient's family and friends to help the individual maintain a family role. Frequently, the patient's illness significantly undermines relationships with such figures and damages the patient's ability to function socially so that intensive and even prolonged therapy must be done in these areas. It is a credit to the community mental health system that it recognizes the need for such help and that it is being done.

The patient's need to establish and maintain his/her position in the field of employment has not yet, however, received comparable attention despite the fact that our culture continues to place strong emphasis on productivity and self-support. Vocational skills are learned later in life, often after the onset of illness, but the patient's illness often impairs ego functions that are essential to vocational functioning. Employers and coworkers also typically have less of an investment than family and friends in maintaining a viable relationship with the patient, making the task of vocational rehabilitation formidable. Yet, the significance of work in the building of a positive and viable identity, and in the acceptance of the individual within the family and social network as well as the community-at-large, is so central that vocational rehabilitation must be included as an essential and integral component of community mental health services.

Rehabilitation as an approach to helping the mentally ill sets forth the expectation that a person function at the highest level at which he/she is capable, emphasizing appropriate social behavior and vocational achievement. Rehabilitation focuses directly on the individual's strengths, helping him/her to become aware of, rely upon, and build upon them. Work activity is seen by the patient, family and friends, and community as a concrete manifestation of this strength. The work setting is also a vehicle through which the individual can develop interpersonal skills, and a sense of confidence in the soundness and resilience of his/her identity. The structure which work activity offers provides the individual with day-to-day support and a sense of security. Finally, the work setting offers a mode for "reality testing" to disorganized or socially alienated individuals. Through the direct guidance of work supervisors and the appropriate role modeling which they offer, the individual can be helped to restructure unacceptable behavior and to develop a positive identity based on the ability to behave appropriately. The acceptance and approval which such appropriate behavior elicits from others help reinforce this behavior.

Organizational Auspices

A variety of state and private agencies provide vocational rehabilitation services to the mentally ill; however the Department of Mental Health and the Massachusetts Rehabilitation Commission each have mandated responsibilities in this area.

Chapter 735, the Massachusetts Community Mental Health and Mental Retardation Act, designates rehabilitation services as one of the service components needed in an area based community mental health system. Rehabilitation services include residential, vocational, and social programs for the mentally ill. The full range of rehabilitation services must be recognized as an essential program component of a community mental health service if patients, particularly long-term chronically ill patients, are to live in the community. Vocational rehabilitation and other rehabilitation services are recognized in Chapters 735 and 991 as essential to the deinstitutionalization and community functioning of the mentally retarded. They are no less essential for the mentally ill.

Since 1943, the federal state vocational rehabilitation program, administered in Massachusetts by the Massachusetts Rehabilitation Commission, has been mandated to provide vocational rehabilitation services to the mentally ill as well as to the physically disabled with the goal of enabling the disabled to become employed. The Federal Vocational Rehabilitation Act of September 1973, directs state vocational rehabilitation agencies to serve the more severely disabled as a priority. The mentally ill are specifically included in the regulations outlining the severe disability groups targeted by this legislation. The goal of employment remains the basis for providing services; however, this population will often require long-term, comprehensive services to function in sheltered or competitive employment.

A new opportunity, thus, exists for the Department of Mental Health and the Massachusetts Rehabilita-

[1] Several of the following recommendations were first set forth in *Helping All The Handicapped: The Report Of The Massachusetts Vocational Rehabilitation Planning Commission*. Although the Report, commissioned by the Massachusetts Rehabilitation Commission (MRC), was published in 1968, the specific recommendations cited here have yet to be implemented. It is our hope that this Manual will promote and facilitate such implementation.

tion Commission to work cooperatively in meeting the vocational rehabilitation needs of chronic patients. In order to do this, it is necessary for the Department of Mental Health, and each of its area community mental health programs to become directly involved in the delivery of vocational rehabilitation services. This is necessary to the maintenance of continuity of services, to the full utilization of Massachusetts Rehabilitation Commission resources, and to the execution of the Department of Mental Health's responsibility for the maintenance and reintegration of the emotionally disturbed individual in the community.

Top-level administrative support for cooperative planning is vital, but actual programs must take root at the area level. While each area is mandated to assess the needs and assure the providing of these services, actual delivery will be undertaken under a variety of private and public auspices. The network of vocational rehabilitation services will probably vary considerably from one area to another depending on such factors as density of population, availability of public transportation, and the nature and extent of employment opportunities. The need for expansion of vocational rehabilitation facilities in each area will depend on the availability and quality of present resources and the increase in demand for these resources as concerted efforts are made to keep patients in the community.

Program Content

Rehabilitation Services

The process of returning or introducing the patient to work activity and then helping him/her to progress within this "world of work" involves the rehabilitation worker in direct client work as well as in program development. Since frequent, or at least periodic, fluctuations in functioning are widespread for many psychiatric patients, mental health rehabilitation in contrast to rehabilitation of the physically disabled tends to assume a more open-ended quality. Depending on the patient's need for long-term services, evaluation and counseling may be an extended process with changes in work placement reflecting the ups and downs of the patient's condition. For most patients, the rehabilitation process will result in a gradual increase in functioning and maximizing of potential.

Comprehensive Planning, Coordination, and Consultation: A rehabilitation worker should participate as a team member in intake, comprehensive treatment planning, ongoing assessment, case conferences, and discharge planning. Thus, each patient has the benefit of a treatment plan which integrates input from all relevant disciplines and is implemented in a well-coordinated way.

Evaluation and Counseling: These services are performed by a rehabilitation counselor so that each patient can be placed in the highest level of work activity at which he/she can achieve success immediately. The patient is then helped to proceed to the highest level of work activity of which he/she is ultimately capable. Vocational and rehabilitation evaluation overlaps with overall clinical assessment and should be done upon admission as well as on a continuing basis thereafter. Evaluation is based upon data from a number of sources: (a) patient history with special emphasis on education, training, and previous work experience; (b) the observations of the rehabilitation counselor in counseling sessions; (c) the clinical judgments of other mental health workers involved with the patient directly or on a consulting basis; (d) formal tests, both written and performance, on aptitude, work tolerance and interest; and (e) patient behavior in work activity placements.

The counseling relationship is the structure in which the vocational rehabilitation counselor and patient work together most directly. This relationship begins at an early point in the patient's treatment and may transcend movement from one unit to another, based on fluctuations in the patient's condition. The relationship represents an alliance between counselor and patient to work together to develop short- and long-term plans, effect placement, cope with problems of vocational adjustment and obtain necessary support. Counseling may be structured on an individual or group basis. The latter may be established as an adjunct to other treatment modalities in individual service units. For example, a vocational counseling discussion group may be one of a number of activities in a partial hospitalization program or an evening vocational counseling group might be held in a residential facility for those working during the day. Patients should be encouraged to take maximum responsibility in this process as a means of promoting increased autonomy.

Placement and Interfacing: Within the community mental health system, the rehabilitation worker is responsible for advocating and overseeing the placement of patients into appropriate work activities. In relationships with these program units, the rehabilitation counselor develops and coordinates mechanisms which permit the smooth unimpeded entry of patients into work activities. Appropriate counseling activity also is enhanced by sound relationships with treatment, residential, and work activities personnel.

The rehabilitation worker also has responsibility for placing patients in work activities in the community. In this capacity, he/she works with professionals in other agencies or with employers who may arrange, finance, or directly provide training or work activities (including competitive employment).

Work Activities

The work performed by psychiatric patients need not be only in the competitive work force. Patients who are unable, at any given time, to meet the demands of competitive employment can be provided with meaningful, relevant, and dignified work activity at a level at which they can experience some success. While many can then progress to more ambitious work activities and to competitive employment, others may only be able to sustain their vocational functioning in a sheltered setting. Suitable work activities must be available to all patients, regardless of their level of functioning.

Access to such work activities must be smoothly and easily achieved, with free movement between levels of work activity for those whose level of functioning suggests advancement to a higher level, or retreat to a less demanding work setting. The first priority is to see that a variety of work activities exist which provide for a continuous progression from the most basic activities of daily living and graded occupational therapy activities to the training and placement of patients in responsible positions in competitive employment. Such work activities can and should overlap in terms of acceptable levels of functioning so that options will be open to patients and their counselors. It is essential that no gaps remain lest a patient be blocked from advancement by having to go from too easy to too difficult a placement.

Occupational Therapy: Inpatient and partial hospitalization programs include activities of various kinds, such as manual and creative arts and tasks of daily living, which assess and develop the patient's ability for self-care and for performing a task in response to the expectations of others. A variety of such activities must be provided in these treatment settings, with ongoing evaluation of the patient's cognitive, perceptual-motor, and interpersonal functioning. For some patients these activities will represent a stabilizing structure of easy tasks which help them to control their emotions and behavior and return to a previous level of functioning. For more regressed individuals, these activities represent a tangible achievement, and a beginning level of satisfying, successful work activity.

Specific Work Activities in Treatment and Rehabilitation Settings: Within full and partial hospitalization programs, halfway houses, psychosocial rehabilitation programs, and social clubs, such activities as meal preparation and serving, furniture set up, light cleaning, and the maintaining and posting of lists, schedules, and announcements can be organized into a program of limited structured work. Activities which are therapeutic as well as necessary to the program's functioning can be the responsibility of the clientele and, thus, foster responsibility, self-sufficiency, cooperation, and self-esteem.

Workshop-Work Activity Center: A workshop should have a close relationship with the treatment setting and place minimum demands on the patient in terms of reliability and established work habits. This workship should accept referrals quickly without the delay of a formal or extensive intake procedure. It should permit work activities which are simple and easy for patients whose vocational and social skills are minimal and who might still be preoccupied, disorganized, or behaving inappropriately. Patients' programs would vary from a few hours a week to a full workweek, with enough flexibility so that changes could be made promptly in response to a patient's progress or to flareups in his/her symptoms. Such a workshop program could be established and operated directly by the mental health rehabilitation team, or by a special contractual arrangement. A system whereby fees are arranged on a per-client basis, such as the typical contractual arrangement between the Massachusetts Rehabilitation Commission and private workshops, may be unfeasible for such patients.

Sheltered Workshops: Workshops which more closely simulate actual competitive employment would be a next step. They should offer a variety of work and job training experiences for both transitional and extended employees, require a higher level of commitment, investment, and functioning, and involve a more formal and extensive referral procedure. The Massachusetts Rehabilitation Commission model of authorization and sponsorship on a per-client basis would be feasible; and, in fact, this is the typical workshop service provided by the Massachusetts Rehabilitation Commission in most areas. Once again, pay would be at the established workshop rates.

Hospital Work Training Programs: State hospitals historically have depended heavily on patient labor to help carry out maintenance functions. The Sauder decision (December 1973) ruled that the minimum wage provisions of the Fair Labor Standards Act now apply to working patients. To facilitate deinstitutionalization, state hospitals should prepare working patients for meaningful jobs in the community. By spring 1975 it is expected that tasks will be identified for each work area and clustered to correspond to community jobs. Patients would be assigned to a job cluster and trained according to the job requirements with attention given to developing work adjustment skills and identifying unacceptable social behavior on the job. Patients gaining proficiency would be considered for community placement. Compensation would be made according to the Fair Labor Standards Act's provisions based on productivity. Under the law, personal chores and the maintaining of one's living area would be exempted providing that they do not exceed one to two hours per day.

Primary Manufacturing: State hospitals and mental health centers, either under their own auspices or under the auspices of privately incorporated workshops, may develop primary manufacturing programs. Products produced would be sold through various outlets and the proceeds returned to the patients. Training and worker adjustment skills thus developed would help prepare the patient for community placement.

On Site Supervised Work Activity: Creative use of private industry to provide transitional work settings is an area of rehabilitation yet to be fully explored but which has undeniable merits in terms of economy and effectiveness. Some rehabilitation programs assume responsibility for performing one or more jobs on a subcontract basis and then employ patients to work at the industry site under staff supervision. Working conditions thus can be adjusted to suit the patient's needs. Sometimes, a company, without requiring a subcontract, will design a position specifically as a transitional or rotating placement for patients.

Patient-Run Enterprises: Patients, with the help of hospital staff, could offer their services to the community as a way of facilitating their work adjustment and preparing themselves for community living. Groups of patients offering their services in painting, landscaping, housekeeping, janitorial services, etc. would give clients an opportunity to interface with the real work-a-day world. Patient-run enterprises could result.

On-the-Job Training, Vocational Education, General Education: Educational programs which lead directly to jobs are obviously of value, but the value of education as an activity itself should not be overlooked. Educational programs which require skills and effort comparable to those in work settings are often less threatening and can greatly enhance self-confidence and self-esteem. The Massachusetts Rehabilitation Commission could be involved in the planning, placement, and financing of eligible clients in these programs.

Volunteer Work: Volunteer work activities in a nonprofit enterprise rather than in settings where such efforts are a substitute for paid work could be used as a means to a specific rehabilitation goal. However, the issue of exploitation and the need to encourage the individual toward self-support should be considered carefully before volunteer work is chosen.

Competitive Employment: Finally, an active relationship between private and public employers and mental health rehabilitation counselors should be maintained to facilitate placement of capable individuals in competitive employment. The Mental Health Job Placement Project is a good example of a direct approach to the establishment and maintenance of such a relationship. Such a partnership between rehabilitation programs and industry can enhance the community standing of all area mental health programming while facilitating the establishment of on site work activity arrangements and competitive job placement.

Staffing Patterns

It is beyond the scope of this Manual to present a detailed overview of the staffing patterns required for the entire range of area rehabilitation services. It is essential, though, to examine the staffing components required to provide the supportive rehabilitation services and work activities described previously. Staff must work directly with the inpatient, partial hospitalization, and outpatient units of each area.

Within each area, a position should be established for a community rehabilitation coordinator. Secondly, vocational rehabilitation-oriented staff should be organized into an area rehabilitation team.

Community Rehabilitation Coordinator

This individual would be responsible for overseeing all aspects of the Area Rehabilitation Program including vocational rehabilitation, community residences, and socialization and recreational programs. Accountability to the Area Director would underscore these services as essential to community mental health programs.

The community rehabilitation coordinator's responsibility for functions related to vocational rehabilitation programming could be delegated to other rehabilitation staff members. The responsibilities include the following:

1. Integrating vocational rehabilitation services into overall treatment philosophy of the mental health system. At an executive level, the community rehabilitation coordinator would represent a vocational rehabilitation perspective on policy-making committees, with the Area Board, and in negotiations with individual unit heads. He/she will have a particular responsibility for gaining administrative support for the efforts of rehabilitation workers and student interns.
2. Supporting rehabilitation workers as persons with a specific functional identity and programmatic orientation. The community rehabilitation coordinator gains administrative sanction for appropriate involvement of rehabilitation workers in treatment teams in all clinical units.
3. Identifying and articulating vocational rehabilitation concerns in relationships with the Massachusetts Rehabilitation Commission, the Department of Mental Health, and other agencies. In working closely with vocational rehabilitation line staff and heads of other programmatic area components, the communi-

ty rehabilitation coordinator is able to assess and articulate patient needs for vocational rehabilitation programs and effectively negotiate for appropriate resources.

4. Providing supervision, training, and supporting research. The community rehabilitation coordinator would provide directly, or at least insure, adequate supervision for all rehabilitation oriented personnel. He/she would have responsibility for participating in the overall training activities of the area. In addition, the community rehabilitation coordinator would promote relationships with university programs to support training of students and encourage research.

Qualifications for the community rehabilitation coordinator should include the following criteria:

- Several years of experience in rehabilitation programs and services for the mentally ill, including experience with inpatient and partial hospitalization programs.
- Several years of administrative experience with demonstrated abilities in interpersonal skills, written communication, and leadership.
- Training in psychology, psychiatry, rehabilitation counseling, social work, or nursing. Specific disciplinary training should not be a primary consideration.

Salary would be commensurate with the qualifications and status needed to function effectively.

Area Vocational Rehabilitation Teams

The organization of vocational rehabilitation workers into teams will provide an effective vehicle for implementing specific program needs. Basically, the team will consist of rehabilitation workers who work directly with staff and patients in clinical treatment units. These individuals, working under the community rehabilitation coordinator, have direct responsibility in supporting patient involvement and movement in work activities. Specific team composition will vary based on area preferences, resources, and developmental issues.

If there is joint sponsorship of area vocational rehabilitation teams by the Department of Mental Health and the Massachusetts Rehabilitation Commission, specific agreements concerning areas of responsibility, lines of authority, evaluation of performance, and use of case service funds would be negotiated best at an area level. Other options might include participation in team support by local mental health associations, private sheltered workshops, and other psycho-social rehabilitation programs.

Staffing for area vocational rehabilitation teams should be pragmatic and undertaken with maximum flexibility to permit optimal responsiveness to patient and program needs. Vocational rehabilitation staff may include individuals at various levels of training and experience in a variety of disciplines ranging from those with little formal training to those with certification and advanced degrees. Staff might include psychologists, rehabilitation counselors, social workers and nurses. Students in training also could play a valuable role in service delivery as part of a carefully planned internship program. It should be noted, however, that each team should include at least a minimal number of professional rehabilitation counselors who by virtue of their disciplinary training could undertake certain tasks and provide leadership in emphasizing a vocational rehabilitation approach to treatment.

Civil Service positions and salary schedules must be modified to encourage individuals to work in mental health-vocational rehabilitation oriented, publicly operated programs which provide a reasonable expectation for professional growth, advancement, and compensation commensurate with skills. Efforts should be undertaken to deemphasize specific disciplinary requirements for Civil Service positions, focusing instead on skills which transcend individual disciplines. Alternatively, blocks for professional rehabilitation counselors should be created in the Department of Mental Health. A further option is to contract for rehabilitation services with a nonprofit organization linked to the area program.

Costs

The Boston Center House, Inc. operates the Center House Workshop in which 58 persons participate, 35 on a full-time basis and 23 on a part-time one. The Center House has an affiliation agreement with the Bay Cove (Tufts) Mental Health Center through which staffing funds are made available for the Workshop. The staff employed to operate the workshop include a director, three workshop supervisors, and a business manager, all full time. Part-time personnel include a secretary (three-fifth's time) and a bookkeeper (one-fifth time). Income and expenses associated with this program for 1974 are identified below.[1]

Income

Subcontractors	$ 64,058.52
Massachusetts Rehabilitation Commission	6,964.50
Fees	1,655.00
Bay Cove (Tufts) Contracts: Phases I and II	35,932.29
Commonwealth of Massachusetts — WIN Program	794.29
Total	$109,404.60

[1] The net gain of approximately $5,000 is a bookkeeping artifact in that certain expenses were not posted until early 1975.

Expenses[1]

Salaries (including Retirement and Payroll Taxes)	$ 63,137.99
Clients' Payroll	35,312.69
Work Activity Expenses (Furniture, Supplies, etc.)	5,617.43
Work/Study Students	357.85
Total	$104,425.96

Income Sources

Since the vocational rehabilitation services require a complex network of facilities, programs and staff, a variety of private and public income sources have been utilized to support these services. The following outline categorizes the traditional sources of support and suggests new funding possibilities to be explored to expand vocational rehabilitation services to the mentally ill.

Private: Mental health associations, private rehabilitation facilities, United Way, foundation grants, and fund-raising.

State: (1) Department of Mental Health: Staffing (Rehabilitation counselors in mental health facilities, staff blocks for programs); Contractual Purchase of Services (Workshops and social rehabilitation facilities); and (2) Massachusetts Rehabilitation Commission: Staffing (Massachusetts Rehabilitation Commission counselors assigned to facilities); Fee for Service (Workshops, other rehabilitation programs, and extended employment support).

Federal: (1) National Institute for Mental Health: Grants as part of community mental health, aftercare, and rehabilitation services; and (2) Rehabilitation Services Administration: Facilities, construction, equipment, and expansion grants.

Local: Comprehensive Employment and Training Act: Funds to provide employment and training to unemployed, e.g. for paraprofessional and other staff positions.

[1] Workshop space is provided Center House without cost by the Lindemann Mental Health Center.

Service 6: Social Rehabilitation

For many mentally ill individuals, participation in work activities, sheltered workshops, competitive employment, volunteer work programs, partial hospitalization programs, inpatient programs, and the like are not feasible. Therefore, a social rehabilitation program emphasizing the development of social skills is essential. Social rehabilitation programs represent a diverse group of individual and group activities. They have as their main purpose assisting those who are, or have been, mentally ill to improve upon their abilities to cope and adjust within social situations at all levels of interaction. They may be part of a vocational rehabilitation program, community residence, partial hospitalization program, and/or inpatient program, i.e. they need not be separate and distinct organizationally although they should be programmatically distinguishable for evaluative purposes.

Organizational Auspices

Social rehabilitation services may be provided by a proprietary, private nonprofit, or public agency. A private nonprofit corporate structure has the advantage of being able to raise and retain income from a variety of sources. Such programs also may be jointly organized by groups and agencies of differing structures. No matter how organized, the social rehabilitation program should provide services for a wide spectrum of needs among the mentally ill. Client participation in such programs should not be restrictive but rather representative of citizens residing in the community within which such a program is taking place.

Social rehabilitation programs hould have a recognizable structure with lines of accountability clearly delineated to the Area Director and the Area Board. Such programs should represent part of a broader network of services with formal and informal agreements linking them to other constituent members.

When social rehabilitation services are components of a program under the auspices of a vocational rehabilitation program, a community residence, partial hospitalization program, inpatient program, social club program, or other related program, then its structure should be delineated specifically as a separate component.

Program Content

The comprehensive mental health program designed for a catchment area should include the following social rehabilitation services:

- **Remotivation:** This focuses on content which is reality based and deals with current situations. Materials about everyday situations could be drawn together from newspapers, magazines, television, and radio. Task assignments on topics such as payment of taxes, price of food, inflation, and the like would be given with a group report expected.
- **Resocialization:** Internal evaluation of personal direction and needs are essential to assisting the mentally ill approach some degree of growth, even if this is in terms of behavioral control only. Groups focusing on interpersonal variables and the client's daily behavior could be held. Emphasis should be placed on meeting the individual's needs and not those of others, such as family, staff, etc.
- **Skills of Daily Living:** Many mentally ill individuals experience problems in controlling money, planning menus, shopping, buying items under contract, using a credit card, etc. A program aimed at assisting these individuals cope with and understand the essentials of daily life should be held.
- **Recreation:** Day/evening recreational programs provide an opportunity for individuals to pursue passive and active recreational activities in a structured and goal directed manner. Such programs should involve trips, tournaments, socials, meetings with volunteers, etc. They would afford each client a broad range of activities relating to most developmental needs.

These types of social rehabilitation services, as well as similar ones, can be offered in any of several program settings such as the following:

1. **Social Clubs** are formally designated settings where the mentally ill can meet to socialize, develop common interest groups, and seek out meaningful community support through peer group assistance. The social club's availability may vary from one evening per week to seven days and nights per week. However, it represents a major resource for these individuals to gather for socializing and supportive purposes. This setting is especially important for patients not participating in other programs with social rehabilitation components.
2. **Common Interest Groups:** Following the example of Alcoholics Anonymous and Alanon, there has been a growing national interest in groups for mentally ill persons, e.g. Recovery, Inc. and Schizophrenia Anonymous. Such groups allow the ex-patient to find full expression of feelings and emotions regarding mental illness. Further, group and peer pressure may restrain the ex-patient from destructive behavior while providing a major resource at times of crisis.
3. **Psycho-Social Rehabilitation Centers** have

been developed which incorporate social as well as vocational rehabilitation concepts, e.g. Center House in Boston. These centers provide a gamut of psychological and social services for the mentally ill including social clubs, vocational rehabilitation, sheltered housing, and transitional employment. Comprehensive psychosocial rehabilitation centers should be encouraged so that a multiplicity of social rehabilitation activities can be coordinated through one organizational structure. The Commission on Accreditation of Rehabilitation Facilities standards[1] should be used as a guideline for such programs.

Staffing Patterns

The staffing of social rehabilitation programs should include a broad range of skills with less concern for specialization than may be the case with regard to clinical services. The recruitment process should focus on individuals with broad backgrounds who can provide several types of services once trained. The intent, therefore, is to establish functional staffing patterns as follows:

- **Community Rehabilitation Coordinator:** An individual responsible for overseeing all aspects of the Area Rehabilitation Program including its vocational and social components, community residences, and recreational services.
- **Social Rehabilitation Leader:** An individual with demonstrated abilities in one or more of the social rehabilitation activities. The leader provides direct leadership of these activities within a structure and organizational design developed in conjunction with the community rehabilitation coordinator.
- **Social Rehabilitation Aide:** An individual who assists the leader in the operation of a specific social rehabilitation activity.
- **Volunteers:** Each catchment area should have a volunteer program which offers the mentally ill a diverse range of social activities. Interaction with members of the community affords the client an opportunity to renew social skills while developing meaningful relationships with local persons. The emphasis may be more upon the development of a social relationship than any specific outcome.

The Center House, Inc. in Boston operates a social rehabilitation program called Center Club. Through an affiliation agreement with the Bay Cove (Tufts) Mental Health Center, staffing funds have been made available, and the Club employs the following full-time staff: a program director, three MSW social workers, and two persons with college degrees. One of the latter works exclusively on prevocational activities. Staff employed on a part-time basis include consultants in administration and social work (both one-fifth time), secretaries (equivalent of one and one-half time), and a bookkeeper (one-fifth time). Additionally, some clients are employed at the Club in ways intended to encourage their productivity and greater self-reliance. These clients are paid for such activities as light maintenance, serving meals, and working on subcontracts. This staff operate the program for all of Region VI. In 1975 the Club expects to have 275 active members which includes an average of 70 persons attending on weekdays, 30 persons on Saturday and on Sunday, and 250 people attending during any single month.

Facilities

The physical structure occupied by a social rehabilitation program should be inspected to insure that it meets the health and safety standards outlined in existing regulations. Though such facilities may not require certification or licensure, the sponsoring organization should provide for a thorough evaluation with regard to health and safety. These facilities should be centrally located to the degree possible or be located where public transportation allows equal access to all individuals within a given area. Social rehabilitation services can be encouraged in all areas through the use of satellite facilities or by the development of new units. Center House in Boston utilizes facilities in social agencies and other community organizations; facilities on the grounds of state hospitals are intentionally not used for social rehabilitation activities.

Costs

Costs should reflect all direct expenses incurred in the operation of a social rehabilitation program as well as the associated indirect costs. Cost effectiveness for purposes of accountability and realistic maintenance of such programs should be emphasized. Affiliations with existing resources in the community should be encouraged to foster cost effectiveness. This may be achieved by operating social rehabilitation programs within a community residence, sheltered workshop, or similar settings. Comprehensive social rehabilitation programs afford a greater opportunity for diversification, and accountability of such programs is high.

The 1974 budget of the Center Club illustrates the income and costs associated with this program. Major expense categories have been consolidated for this illustration.

It should be emphasized that Center House considers the staff budgeted for this program insufficient since services are provided 76 hours per week spread over seven days. If income continues

[1] Standards Manual for Rehabilitation Facilities. 1975 Supplement amends 1973 Edition. Commission on Accreditation of Rehabilitation Facilities, 6510 North Lincoln Avenue, Chicago, Illinois 60645.

to increase as it did in 1974, additional staff will be hired.

Income Sources

Multiple funding sources are needed to maintain program continuity since total reliance on public funding is unrealistic. Social rehabilitation organizations may generate income through fee-for-service contracts, foundation grants, donations, United Way allocations, and Department of Mental Health resources (including staff assignments). The Center House, Inc. additionally sponsors two major fund-raising events annually.

Income

Contributions		$ 10,000
Dues		3,412
New England Medical Center		38,419
Boston State Hospital		42,500
Massachusetts Mental Health Center		25,000
Interest		200
	Total	$119,531

Expenses

Personnel (including work/study students)		$ 74,926
Payroll Overhead and Retirement		9,272
Rent, Maintenance, Depreciation, Amortization		8,821
Food (net)		6,193
Group Activities (net)		3,488
Office Expense		2,998
Telephone, Gas		2,280
Client Payroll		5,682
Camp (net)		981
Other (Legal, Audit, Insurance, Travel, Miscellaneous)		1,178
	Total	$115,819

Service 7: Community Residences

Community residences are a relatively new resource for the mentally ill. In 1950, there were only two such facilities in the entire United States but in the ensuing decades they have grown at a geometric rate. In 1960 there were 10; in 1963 there were 40; and in 1969 approximately 130 community residences existed throughout the country.[1] By 1974, there were 60 such programs in Massachusetts alone!

This growth stems from the efforts and concern of a comparatively small number of individuals to find less traumatizing, alienating, and costly forms of service than traditional hospitalization. A major rationale for the Massachusetts Mental Hospital Planning Project's recommendation that large state hospitals be phased down is the demonstrated ability of community residences to serve as effective alternatives in providing sheltered living arrangements. In fact, the Massachusetts Department of Mental Health now requires that community residences be included as a sixth essential service in comprehensive area-based programs.

As clinicians have become more sophisticated in minimizing long-term inpatient care, it is evident that several groups of people can successfully utilize community residences. They are:

- Individuals in crisis, coming directly from the community, who require short-term, intensive nonmedical supervision and support. (Many of these individuals are now cared for in state hospitals.)
- Individuals ready to leave a hospital after short-term care but not yet ready to assume the full responsibilities of independent living.
- Individuals who after long periods of hospitalization are capable of personal care but lack social skills and competencies.

In response to the differing needs of each of these population groups, several types of community residences have evolved in recent years. The residents accept varying responsibilities in each according to personal abilities.

- A group residence generally has no requirement that the residents leave for total independent living within a specified time interval.
- A halfway house explicitly expects residents to leave for independent living within a defined time period.
- A cooperative apartment is a group-living arrangement which may become a person's permanent residence, or it may be transitional. No staff live in the apartment.
- A foster family provides room and board for one to three individuals who need an alternative home. The home may provide a permanent or transitional living arrangement.

Under current care patterns psychiatric hospitalization is often over-utilized. This is due to the fact that alternative nonmedical facilities are not sufficiently available in the community for people in crisis. More such facilities should be utilized when intensive medical supervision is not required.

In order to rectify this situation, one of two possibilities exist:

1. Each community residence could have one or two beds available for individuals in acute crisis. This would give such residences maximum utilization; however, two problems might be created:
   - Staff are severely stressed, and this takes their time away from current residents and creates turmoil in the facility.
   - Special fiscal planning would be necessary to accommodate the fact there would be empty beds some of the time.
2. An intensive care residence could be developed. This is a small nonmedical facility providing intensive supervision for crisis management on a 24-hour basis. Residence in the facility is primarily short-term, ranging from one day to two weeks. A person may leave the intensive care residence and return directly to independent living, or be discharged to another more appropriate residence.

Organizational Auspices

There are various organizational auspices possible for the operation and administration of community residences. These include private proprietary or nonprofit agencies, state government agencies, and joint private/state agencies. Operating a nonprofit charitable corporation facilitates the receipt of public funds and foundation grants as well as private contributions. Profit-making corporations can receive state funds through contracts when funds are available for services rendered at a rate compatible with those determined by the Rate Setting Commission.

If a program is operated directly under public auspices, funds may be readily available through the agency's operating budget, or staff may be reallocated from other state programs. By investing

[1] Glasscote, R. *et al. Halfway Houses for the Mentally Ill.* Washington, D.C.: Joint Information Service, 1971.

programmatic and fiscal responsibilities in nonstate organizations while using state funded staff and ancillary supports, maximum flexibility is possible.

Irrespective of the organizational auspices, the following common elements should exist:

- Community residences receiving public monies should relate to their surrounding communities through participation at the Area Board meetings, through community advisory groups, and/or through a house board representing relevant segments from the community.
- Community residences should operate programs providing residential services for a variety of disability groupings. Each facility should operate with adequate administrative autonomy so that important administrative decisions are not made at a site remote from the program and without consultation with the program.
- Contracts should be awarded to each community residence based upon its cost effectiveness, its feasibility, and its plan to utilize available community resources, with the expectation that every effort will be made to develop innovative administrative linkages to support the programs. For example, this may involve private, profit-making landlords with state supported staff, and private, nonprofit administration.[1]
- Affiliation with the Department of Mental Health area program should be maintained to assure proper communication and linkages. Area staff and Board should be involved in decisions regarding the establishment of new residences.

Program Content[2]

Each community residence must insure a variety of services to assist residents in the management of their mental health needs as well as basic socio-recreational needs. These services include:

1. **Intake/Screening:** Each community residence must have a written intake/screening policy which clearly states the basic admission criteria. This policy should assure each candidate for residency the same chance for admission as anyone else who may meet the basic criteria. Restrictions based on age, behavioral patterns, sex, or any other factor should be clearly stipulated so that each candidate and potential referral source will know them. Documentation should be made of this process and findings provided to both candidates and referral sources.

   It is strongly urged that the resident's program and treatment plan be designed upon entrance to the facility in a team meeting with the following individuals:

   - The client.
   - Significant others including family and friends who are involved with the client, or who the client deems appropriate.
   - Community caregivers (teachers, clergy, etc.) who have been involved with the client or would provide needed resources.
   - Staff from the community residence.
   - Mental health clinicians, i.e. psychiatrist, psychologist, and/or social worker.

2. **Goal Development:** A major emphasis should be placed on the resident's participation in the definition of goals while in residence. Goal definition coupled with the delineation of expectations of the resident and the staff in meeting these goals should be pursued. A written program plan should be developed as soon as possible, and not longer than a week after each resident's entry to the program, and reviewed at least once a month and in the case of short-term residents every two days. This plan should emphasize:

   - *Social programs* in the house assisting the development of interpersonal relations that are free from pathological patterns such as isolation and withdrawal, grandiose hypermanic intrusiveness, paranoid suspiciousness, or malevolent manipulativeness.
   - *Avocational interests* in the house such as developing a capacity to be aware of the world about and to engage in social activities such as cards, Monopoly, ping-pong, etc. Outside the house, the capacity to seek and enjoy such social and avocational activities as tennis, swimming, boating, skiing, hiking, and entertainment such as movies, concerts, and art museums.
   - *Vocational planning* so as to ensure that each resident participates in a daily program at maximum potential.
   - *Education planning* either for elementary, high school, or college levels. An educational consultant should participate where necessary in planning goals, in application and entry, curriculum selection, and academic load-level judgments.
   - *Life skills improvement* includes personal hygiene, cooking skills, ability to get around in the community, using public transportation, ability to handle money and a checking account, capacity to shop in local stores, and acquiring knowledge in apartment selection.

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[1] Richard D. Budson, Justine Meehan, and Emily Barclay, *Developing a Community Residence for the Mentally Ill*, Boston: Commonwealth of Massachusetts, 1974.

[2] Items 3-5 of this section are taken from the monograph, Richard D. Budson, Justine Meehan, and Emily Barclay, *Developing a Community Residence for the Mentally Ill*, pp. 18-19.

- *Physical health care management* includes general medical care, dental care, exercise, diet, and birth control.
- *Psychiatric care and therapy.* The client's needs, resources, and problems should determine his/her treatment plan. Relevant therapies may include chemotherapy; individual counseling; family, group, and couples therapy; problem-solving in a social network; day support; types of behavior therapy; short-term and long-term psychotherapy; and crisis intervention.
- *House and staff milieu planning* involves anticipatory consideration of requirements for staff and group to provide support, limit setting, reality testing, confrontation, etc. in individual cases as appropriate.
- *Family Relations.* Planning for crucial relationships with close family members, parents, spouses, children, etc.

3. **Daily Programs.** The daily program in the house usually includes the group eating together nightly, family style, and the group gathering together weekly for house metings. Many models are possible for the house meeting. It may be led by the residents, the house managers, the program consultant, or led jointly. Depending on the program and the needs of the residents, the house meeting may be an informal discussion at meals or a regular meeting of the residents and staff. Such issues as house rules and policies, adjustment of residents to the program, and changes in staffing and acceptance of new residents are all relevant agenda items for a house meeting.

   Housekeeping, cooking, shopping, and minor maintenance of the dwelling also may be part of the in-house program. Residents take responsibility for these chores as they would in their own homes. In addition, small group recreational activities prevail in the evenings such as card games, ping-pong, and television viewing. Another important part of the in-house daily program is the constant availability of the managers for support and advice at times of crisis as well as encouragement and sharing at times of pleasure and success.

   Residents should have a specific program of daily activities, often outside the house. If this is lacking, the community residence may in time begin to function like an institutional back ward. Each community residence must provide a structured program throughout the waking hours which may include school, work (in competitive employment or sheltered workshop), day hospital or day activity programs, or volunteer work. In planning the residence program, consideration should be given to a mechanism for finding appropriate jobs for residents.

4. **Avocational/Recreational.** Residents may need assistance in developing creative and pleasurable uses of their leisure time. The availability of recreational facilities is therefore a distinct asset to any program. These include movie theatres, bowling alleys, parks, YMCA-YWCA facilities, etc. Avocational opportunities also could include religious, civic, social, and other community interests. Vacation time away from the residence during holidays or in the summer should be arranged when appropriate and possible.

5. **Ancillary Services.** Psychiatric, social rehabilitation, and dental services are needed. Residents should be encouraged to utilize local community resources as much as possible, as would any other citizen in the community.

6. **Program Continuity.** Under appropriate circumstances, community residences should develop continuity recognizing that a resident's tenure in the program involves movement toward increased economic, social, and personal independence. Planning with other agencies, the family and related resources is an essential aspect of programming, especially with regard to discharge planning and aftercare.

7. **Use of Community Resources.** Wherever possible, resources already available in the community should be used in developing a resident's program. Total programming within the community residence itself is akin to institutional treatment and, thus, should be discouraged.

8. **House Rules.** Each community residence must develop a manual which clearly denotes the programmatic requirements and expectations of residents. House rules may describe daily costs, services available, fixed and mandatory programs, and other pertinent information as delineated by the residents and staff. Fire and safety rules should be posted on each floor.

9. **Recordkeeping.** Each community residence should develop and maintain an adequate recordkeeping process which includes for each resident: clinical reports, when available, from the referral source; monthly progress notes; periodic notes including medication changes; hospital visits; behavioral problems; clear description of goals and methods to reach them; and delineation of effect when reached. Pertinent fiscal records also should be maintained.

10. **Program Review.** At least annually, each community residence should review its program on

such criteria as outcome for individuals who have entered and left the residence, communication with referral sources, and other data as they are available. Client portfolios also should be reviewed to determine potential discrepancies in programs and in the process of recording them. The purpose of such review is to determine program effectiveness in meeting individual needs and to reflect programmatic changes necessary to meet those needs. Monitoring and evaluation of the program for regulatory and licensing purposes is a responsibility of the Department of Mental Health. Monitoring should be carried out on a regular basis to avoid the abuses that, in some instances, have characterized deinstitutionalization.

11. **Aftercare.** Linkages with community mental health aftercare (outpatient) programs provide continuing care after a person leaves the residence, including follow-up medication review, psychiatric evaluation, and crisis intervention. Follow-up through the community residence, where possible, may serve as a meaningful linkage for the resident and provide for recognition of another source for assistance.

Staffing Patterns[1]

Creative staffing patterns for community residences should be demonstrated through the linkage of state and private resources. This can be enhanced by career development programs aimed at creating new staff classifications. Training aids, training programs, ongoing in-service education, and innovative approaches to staff motivation should be emphasized. The potential for career opportunities in the field of community residences needs to be recognized and stressed. Limits should be placed, however, on the volume of training activities feasible in a given facility.

A new area position of "Community Rehabilitation Coordinator" is recommended. This individual would be delegated the responsibility for coordinating, through the Area Director, the management of a community-based rehabilitation program which includes community residences and related support programs such as social clubs, day activity programs, and socio-recreational programs.

The staffing of a community residence requires:

1. **Residence Director.** The director has the responsibility for the overall coordination of the legal, fiscal, and programmatic aspects of the community residence. Critical to the success of the program is meaningful coordination between the director and the house managers. Those responsibilities assumed by the director and those delegated to the house managers should be delineated clearly. Where a program is under the direction of a corporation, the director should have adequate means of communicating with the corporate body.

2. **In-Residence Management.** A young married couple often is hired as house managers, one being a full-time employee of the program, the other working outside the house each day or attending school and working as a part-time employee in the evenings. It is valuable to have both male and female managers. Provisions should be made for house coverage when the managers are on vacation and on their days off. Often a relief manager is hired on a part-time basis for this purpose. It should be noted that very stressful situations have been encountered by married couples serving as house managers. Other combinations of persons might be preferable, and a variety of sets of house managers should be encouraged.

   When less supervision is needed by the residents, the requirement of in-house management may be waived with the permission of the Department of Mental Health. A possible model might even be that of house managers living in the dwelling as the program is being established but moving out when the residents achieve sufficient autonomy in their own lives and in the house's management. The residents may then continue this living arrangement indefinitely with only periodic visits from staff.

   When hiring house managers, it is often possible to find interested candidates through university graduate programs of social work, psychology, special education, rehabilitation counseling, theology, or other related programs. It is thought to be important for the stability of the residence that the managers be available for at least a year.

   In the case of the therapeutic facility serving acutely disturbed residents, it will be necessary to provide more intense supervision. Community/neighborhood workers and a doctor should be on call 24 hours a day for crisis management.

3. **Professional Consultation.** This should be arranged through the area program. Depending on the needs of the residence, the consultant may meet solely with the house managers advising them on issues regarding the residents and program, or the consultant may meet with the residents as well. Depending on the program's needs, consultation may be arranged with a psychiatrist, social worker, rehabilitation counselor, or psychologist. A consultant should

[1] Items 1-5 in this section are taken from Budson, *et al.*, *Developing a Community Residence for the Mentally Ill*, pp. 15-17.

meet with the program at a minimum of once per month.

4. **Emergency Medical Availability.** Although residents may have their own physicians in the community for routine care, medical treatment in case of medical emergency should be arranged. This arrangement may be with a local physician or emergency room team of a local hospital who should be aware of the program's intention to call upon them when needed.

5. **Volunteers.** The use of volunteers should be considered since they not only supplement the staff but provide a valuable link between the residents and program to the community, assisting particularly in recreational and socialization services. Volunteers also can provide support to the resident returning to a more independent living arrangement. Volunteers may be recruited from universities, churches, local service, and mental health associations.

6. **Job Titles.** Civil Service classifications, specifications, and entrance requirements are not compatible with current Department of Mental Health program needs. The reclassification project of the Department, thus, is urgent. Specifically, job titles should be revised and designed to reflect more closely the work actually performed; Civil Service exams should be offered more frequently and should test more validly and reliably the skills needed for work performance. The requisite criteria for nongovernmental agencies should be competency rather than credentials.

Facilities

A variety of dwellings have been utilized as community residences, including large old homes, lodging houses, multi-family houses, apartments, and inns. The choice of dwelling, from a programmatic viewpoint, should be guided by how it lends itself to a family or homelike atmosphere and by its accessibility to such community resources as shopping, transportation, and the like. Institutional features such as steel doors and cinder blocks walls found in old dormitories or nursing homes generally should be avoided. Although the Department of Mental Health regulations specify a maximum of four persons per bedroom, the number of people in a bedroom should be guided by the room's layout and available space, avoiding a dormitorylike arrangement. Space should be available and adequate for group activities in a living room or recreation room. The dining room should be sufficient to seat the entire group at one time. Attractive decor and furnishings in good condition contribute positively to an overall atmosphere of self-esteem. Encouragement of residents to participate in decorating the dwelling can foster the feeling that it belongs to them.

In general, the community residence should blend in with other dwellings in the neighborhood, not bearing any distinguishing characteristics. It is important to locate in an area which is not isolated, but in the midst of a community, thereby facilitating access to transportation, jobs, schools, shopping, recreational facilities, and appropriate health and social service agencies.

In selecting a residence, particular attention must be given to safety, building code, and zoning regulations.[1]

1. **In-House Safety.** Certain precautions should be taken by the program in case of emergency. Health and safety rules should be developed initially and agreed upon among the residents and staff and subsequently reviewed as population turnover occurs. These rules might include such issues as: smoking, curfews, sex, food and meals, drugs and alcohol, noise, etc.

2. **Building Code.** The Department of Mental Health will review a community residence from a programmatic standpoint only. Community residences are subject to a new building code specifically developed for them under the provisions of Massachusetts General Laws Chapter 143, Section I, as most recently amended by Chapter 1098 of the Acts of 1971. The code has been drafted by the Uniform Building Code Commission with the advisory assistance of the Interdepartmental Rehabilitation Facilities Board of the Executive Office of Human Services. Under this code, the inspection was conducted by the state Department of Public Safety until January 1, 1975, after which time local inspectors assumed this responsibility.

3. **Zoning.** Location of the community residence is guided by the zoning ordinances of the cities and towns in Massachusetts. These cities and towns have authority over such factors as density of population of a neighborhood, and height, size, location and use of buildings, structures and land for trade, agriculture, residence or other purposes (Massachusetts General Laws, Chapter 40-A, Section II).

   In many communities detailed zoning ordinances are being written regarding the location of community residences. Since the community residence is a single housekeeping unit of persons living together as a family, the preponderance of ordinances have identified all

[1] Items 1, 2, and 3 of this section are taken from the monograph, Richard D. Budson, Justine Meehan, and Emily Barclay, *Developing a Community Residence for the Mentally Ill*, 1974, pp 8-10.

residential zones as appropriate for these dwellings. In some cases, these community residence ordinances have included a requirement that the program obtain a special permit before locating.

Where zoning ordinances specifically addressed to community residences have not been drafted, the residence often is considered to be a family for zoning purposes. Some communities, in fact, identify a single housekeeping unit, without any reference to degree of kinship of the residents (Danvers, Massachusetts Zoning Bylaws, p. 2). A recent Supreme Court decision puts the family argument into some jeopardy.

It is important to understand that components of the decision-making by planning boards, etc. under the authority of Chapter 40-A include political and public relations considerations. These may be voiced by citizens at a public hearing and, therefore, community relations play a key role in the location of the community residence.

Sources of Income

Income to meet expenses may be obtained in a number of ways. Individual residents generally are charged a daily fee which may be derived from one or more of the following sources: (1) supplemental security income checks; (2) family support; (3) earned income from employment; (4) third-party payments; and (5) savings.

As a general rule, unless most residents can afford to pay a fee of $10 to $20 per day, a program must rely on additional sources of income. Purchase of service contracts seem essential in recovering program costs when income is not available through other agency sources. Contracting, where needed, can occur only between state and private nonprofit or private-for-profit groups or individuals. Cost effectiveness should be an integral component of accountability for community residences. Such costing procedures should include all costs and not only those incurred by one sector or sponsorship.

The critical cost factor associated with staffing may be dealt with through a linkage of state and private providers. Assignment of state employees as part-time professional staff would reduce the cost for the provider as a direct expense, thereby reducing the overall operating budget significantly.

As noted previously, cost variability relates to the differing types of community residences now in operation. It thus is appropriate that rate setting should be on an individual program basis. Further, community residences are subject to cost-of-living increases, requiring that their basic rates change frequently. Contracts should reflect an awareness and consideration for this variable. Community residences should be considered eligible for surplus food stuffs and surplus purchasing. Where possible, community residence sponsors may wish to enter into cooperative arrangements to make use of group purchasing power and centralized disbursement benefits.

Costs

The costs of operating a community residence program can vary considerably. The costs of 18 existing and typical community residences have been calculated as follows:

Table 2-8. Community Residences: Income And Expenditures

	Range	Median	Mean
Income	$ 6,176. — $263,071.	$31,561.	$57,528.
Expenditures	6,473. — 261,504.	36,422.	46,942.
Balance	(13,917.) — 22,150.	549.	483.

Table 2-9. Community Residences' Expenses

	Range	Median	Mean
Manpower	$ 0 — $111,666.	$10,363.	$19,003.
Equipment	0 — 6,453.	0	1,308.
Supplies	0 — 7,591.	377.	1,259.
Food	0 — 29,432.	6,046.	7,133.
Transportation	0 — 4,768.	100.	888.
Rent	0 — 18,283.	1,401.	3,455.
Mortgage	0 — 6,984.	0	1,105.
Insurance	0 — 17,076.	500.	1,369.
Utilities	240. — 18,714.	1,954.	3,083.
Other	500. — 49,561.	2,932.	8,136.
Cost per diem per bed	2.96 — 24.69	9.10	10.06
Charges per diem	3.57 — 21.42	6.34	10.27

Service 8: Hospital Care and Treatment

Most mental health programs emphasize 24-hour care provided in hospital settings. As we become increasingly sophisticated in the uses and benefits of alternatives to hospitalization, 24-hour inpatient care is no longer regarded as the major treatment of choice. Consequently, one of the goals in developing comprehensive community mental health programs is to reduce hospitalization and to shorten its duration when required. When available, therapeutic facilities, halfway houses, group homes, detoxification centers, developmental disabilities centers, and other community residences are viable alternatives to hospitalization. Once an area has developed a network of community resources of the types described in this Manual, these resources should be able to handle many and perhaps even all patients now admitted to hospitals.

In moving services from state hospitals to community settings, program directors must be sure to include the full range of physical and medical support services currently required for accredited hospital care. Locally based programs must adapt to the character of the community being served and to the increasingly common practices of brief inpatient stays during acute crises followed by early discharge into appropriate community settings. To facilitate this goal, hospital programs should maintain functional relationships with other components of the community-based mental health service system.

Appropriate Utilization of Hospitalization

Hospital services are the most costly of all mental health services. Their use, therefore, should be limited to the following circumstances:

- When the patient's medical needs require diagnostic or treatment facilities available only in hospitals.
- When the security of the patient, his/her family, or the community requires 24-hour care.
- When the patient's treatment can be adequately controlled only in a hospital setting (e.g. medication or physiological emergencies such as seizures).
- When no other facility is appropriate for around-the-clock observation.

Hospital care is not appropriate for providing emergency shelter, for extracting a client from a stressful social setting, for impressing on the client the fact that others are disturbed by his/her behavior, or to relieve the family of a distressing burden. Furthermore, the fact that "Blue Cross will pay" does not justify hospitalization except where this kind of care is the best method of treating the person.

Populations at Risk

In planning and developing hospital services, an initial step is for area staff to identify the specific populations who may potentially need this care. The following groups require consideration:

Adult Mentally Ill

The largest group potentially requiring 24-hour hospital care are adults whose mental illness and emotional problems are manifested by psychosis, suicide attempts, severe depression, episodes of confusion, etc. Within this large group, it is important to distinguish the two subpopulations with unique program planning and facilities needs.

1. Patients Currently Residing in State Hospitals.

These individuals have multiple social, medical, and psychiatric handicaps. When discharged from state hospitals, alternative community facilities must be available. "Dumping" these persons constitutes inhumane treatment and generates community "backlash."

The Department of Mental Health in December 1973 reported statistical data by catchment area on all patients in state hospitals. This report is available through the Department of Mental Health's Central Office Division of Evaluation, Research, and Statistics, and can be of considerable assistance to areas in planning for deinstitutionalization. There are approximately 100-200 residents per 100,000 population in state hospitals, the exact number depending on such factors as socio-economic status, availability of halfway houses, institutional policy, and community tolerance and acceptance. Increased public concern is being expressed about this hospitalized population, and Area Boards and staffs should carefully review their needs to determine clinical and social readiness for transfer from institutional to community facilities. The availability in the community of such human services as psychoactive drug supervision and monitoring, physical health care, community residences, halfway houses, day treatment, vocational rehabilitation, Welfare Department disability assessment, etc. should be assessed as part of the planning process since it has a major bearing on the number of patients needing continuing hospitalization in order to receive adequate care.

In 1972, social work staff of the Department of Mental Health analyzed the functional needs of patients residing in state hospitals; 6,500 patients in 10 state hospitals were categorized into the following four functional groups:

- *Ambulatory Patients with Predominant Medical Problems.* This group included 2,775 persons, or 35 percent of the total. "Ambulatory" was defined as being able to walk the length of a hospital corridor and up a flight of stairs. Members of this group had physical problems which were getting progressively worse; they required a large amount of nursing care but relatively little psychiatric attention. These patients could be appropriately cared for in Levels I and II nursing homes.
- *Ambulatory Patients Who Are Psychotic.* This group included 1,950 persons, or 30 percent of the total. They have been in state hospitals for 10-40 years and have great need for social stimulation and close supervision. Many patients in this group have substantial mental retardation.
- *Ambulatory Nonpsychotic Patients Who Are Institutionally Dependent.* This group was comprised of 1,300 persons, or 20 percent of the total. Its members were placed in state hospitals many years ago and consider them "home" since ties with families have been severed. These persons were for the most part quiet and cooperative, they work on the hospital grounds and function dependently within the institutionalized setting.
- *Acutely Psychotic Clients Who Require Short-Term Hospitalization.* These persons are inpatients for approximately 10 to 15 days of crisis intervention and comprise 975, or 15 percent of the total. Psychiatric units in general hospitals or community mental health centers could treat most of this group, for whom intensive medical and psychiatric services are often necessary. Day and evening treatment centers can best provide continuing care to these patients after the acute crisis has passed.

The findings of this 1972 study clearly indicated that a large proportion of the 6,500 persons then residing in state hospitals could be cared for equally well in alternative settings. Approximately 4,000 persons, or 62 percent of the total, could have been transferred to other facilities if such settings were available. It is important to emphasize again that the first step in moving patients from the area's state hospital unit to alternative care programs is evaluating the client's specific needs and capabilities. Since many hospitalized patients function better in settings with higher expectation levels, it is strongly recommended that all hospital patients be evaluated and a range of alternative settings considered.

If the goal of reducing the number of patients in hospital settings is to be achieved, communities must develop the residences and therapeutic facilities described elsewhere in the Manual. These include nursing and rest homes for persons needing a high degree of long-term supervision, intensive care facilities for those requiring short-term intensive psychosomatic supervision and care, halfway houses and group homes for those needing minimal supervision, and cooperative apartments for those needing little if any supervision. It is especially important that it be possible for patients to move from one residential setting to another as they become able to live more independently. Flexibility in area programs will foster patients' growth and independence; administrative rigidities will inhibit them.

2. **Newly Admitted Adult Patients.**

Based upon national statistics, each catchment area can expect 800-1,000 annual inpatient admissions per 100,000 population. Only about half of these episodes take place in public facilities—county, state, or Veterans Administration. The other half of inpatient care is provided by psychiatric units in general hospitals and private mental hospitals. It is of note that as recently as 1971, Massachusetts ranked well below the national average in utilizing psychiatric units in general hospitals but above the national average in its use of public and private facilities.[1] During the succeeding years, psychiatric services in general hospitals have been growing; the Massachusetts Hospital Association reported that in 1974 thirty of its members operated such services. Thus, area planning for the psychiatric needs of persons who must be hospitalized should include the full gamut of services available through private, voluntary, and public hospitals. Area planning also should consider the range of services needed to reduce the duration of hospitalization as well as alternatives to inpatient care itself.

Aggressive and Potentially Violent Male and Female Patients.

A small number of patients require a secure unit with locked wards and careful supervision. The general feeling of planners and administrators is that these patients are best cared for in a regional facility. In fact, a Department of Mental Health Task Force is planning such a program now. Regions should be extremely cautious and wary of creating such institutions which may become: (a) means of repression for certain deviants, (b) means to "lock up problem people" rather than meeting their needs, and (c) an exporting mechanism for areas, communities, and neighborhoods. It is strongly urged that area programs try to deliver services to members of this group through local program components whenever possible.

Legal Offenders

A moderate number of adults are referred each year from the courts to the Department of Mental Health

[1] Massachusetts Mental Hospital Planning Project, *Community Mental Health And The Mental Hospital*, 1973, P. 12

for evaluations of competency to stand trial for an alleged offense or because they display emotional problems while in correctional institutions.

Children

There is currently a serious shortage in Massachusetts of inpatient and/or residential services for children. Although the number of children who require 24-hour care for strictly psychiatric reasons tends to be very small, when the need does arise, it involves a complex mixture of medical, psychiatric, and social services. The only inpatient facilities currently available for children are the Gaebler Unit at Metropolitan State Hospital in Region III, and the League Day Program School at the Erich Lindemann Mental Health Center and the Massachusetts Mental Health Center in Region VI. With this limited bed space, clinicians have had to place children in state hospitals, pediatric services of general hospitals, and group or foster home placements. This situation has created serious public concern; its resolution will require ingenuity as well as long-term planning and advocacy at the area program level.

A combination of residential/day schools should be established for severely disturbed children needing intense supervision. Because of the small number of children who would benefit from a special school, it may be necessary to establish the school on a multi-area or regional level. The Department of Mental Health has already developed five residential mini-schools for autistic and seriously disturbed youth as well as 27 day mini-schools. Such mini-schools would replace public school education only in the most extreme cases; Department of Mental Health staff should always attempt first to develop programs for emotionally disturbed children within their local school system.

Developmentally Disabled and Mentally Retarded

Approximately 30 percent of the persons now residing in state hospitals are considered developmentally disabled and/or mentally retarded. If these individuals are to be served in an alternative system, appropriate community facilities must be established for them. These facilities should be planned in conjunction with the Regional Administrator for Mental Retardation, an area coordinator for mental retardation, and the newly evolving geographic units within state schools.

Adolescent Patients

About 120 seriously disturbed adolescents between ages 14 and 18 now reside in adult units of state hospitals. There is an increased awareness of the need to design services more relevant to their needs. Some advocate separate adolescent units specifically geared to the developmental and educational needs of this age group. Others assert that fully separate units are clinically unmanageable; adolescents should participate in unique day and evening programs but reside on adult units.

The Department of Mental Health is experimenting with both types of programs at several state hospitals. A program for Bridgewater State Hospital youth will be housed under contract at the Solomon Fuller Center in Roxbury. In addition, residential facilities for troubled adolescents rapidly are developing outside of the hospital system. Examples include Freeport in Newton and the network of community residences developed for youthful drug dependents by the Division of Drug Rehabilitation. It is recommended that adolescents not be treated in hospital settings if at all possible. As another treatment model, disturbed adolescents can be treated in therapeutic day programs related to educational programs, such as the Woodward School at Worcester State Hospital or the Robert W. White School at the Erich Lindemann Mental Health Center.

Geriatric Patients

Elderly persons frequently become Department of Mental Health patients because, in addition to medical and neurologic problems, they have psychiatric problems often manifested by dementia, confusion, memory difficulty, difficulty in locomotion, incontinence, wandering, etc. Such persons pose difficult placement problems. There is a moderate but significant group of geriatric individuals too chronically ill for acute medical hospitals and/or who are too disruptive or confused for nursing homes. They get transferred or committed to Department of Mental Health facilities; hospitalization then is often protracted because of difficulty in locating alternative placements.

Admission rates for geriatric individuals can be reduced when mental health centers effectively utilize specially trained geriatric consultation teams which establish liaison with nursing homes, rest homes, and general hospitals. The geriatric specialists consult with staff at such institutions about management and behavioral problems, prevention of psychosis, treatment of depression, and other problems. The liaison work of the Massachusetts Mental Health Center's geriatric consultation team was described in the Manual's earlier section on Consultation and Education.

Despite the success of these efforts, nevertheless, there remain geriatric patients who require the medical, neurologic, and social service resources found only in hospitals. It is estimated that 50-100 elderly persons per 100,000 population will require such services annually. The availability of Medicaid has significantly reduced the number of geriatric mentally ill patients admitted to public hospitals, but there still remains a group of geriatric persons whose needs are met by neither nursing homes nor

general hospitals.

Alcoholics

Alcoholics requiring 24-hour care often have severe intoxication problems and withdrawal syndromes such as D.T.'s, hallucinosis, and Wernicke's syndrome. A large number of these persons also have medical problems. In many states, 20 to 30 percent of admissions to psychiatric hospitals are related to alcoholism. Since July 1973, the Department of Public Health in Massachusetts has facilitated the opening of a network of detoxification centers throughout the state. The availability of such facilities has reduced greatly the demand for admission of alcoholics to mental health facilities. However, alcohol detoxification units do require psychiatric backup for problems such as suicide, hallucinations, confusion beyond the initial period, and severe personality difficulties. Liaisons need to be established with these detoxification centers and procedures developed for admission and for transfer to aftercare programs such as AA, halfway houses, and vocational rehabilitation programs.

Drug Dependent Persons

There is a small but significant number of persons with serious drug abuse problems who require 24-hour care, often on an inpatient unit. Special medical problems exist with persons addicted to barbiturates and related drugs, and who also may be involved with amphetamines or who have had very serious "bad trips" with LSD or mescaline. Heroin problems have recently become less of a burden on mental health facilities because of the network of programs developed by the Division of Drug Rehabilitation. The addict's short-term need is for hospitalization for detoxification. Long-term problems of rehabilitation are best handled through self-help groups and the various halfway houses established by the Division of Drug Rehabilitation.

Organizational Auspices and Facilities

Four types of organizations can provide hospital care within comprehensive treatment programs for the mentally ill. They are the following:

1. **Unitized Programs in State Hospitals.** These units currently are the largest publicly operated providers of hospital care for all types of adult patients. Traditionally controlled by hospital superintendents, these units increasingly are coming under the budgetary and clinical control of area program staff and Area Boards. It is anticipated that over time, staff and patients from these units also will be shifted to the community. For example, when 10 patients are returned from the unit to community facilities, one state hospital staff member should accompany them to provide aftercare and help develop other necessary services. Many innovative programs have been developed by state hospital units. Area programs must accept responsibility for these units and recognize that they are a major resource from which to arrange staff reallocations under proper conditions.

2. **Community Mental Health Centers.** There now are several freestanding community mental health centers with inpatient capability. The oldest is the Massachusetts Mental Health Center; others include the Corrigan Center in Fall River, the Solomon Center in Lowell, the Erich Lindemann Mental Health Center in the Harbor Area, and the newly completed Fuller Center in Boston. Plans are under way for construction of similar centers in Pittsfield and in the South Shore Area.

   It is not expected that additional freestanding centers will be constructed. Enthusiasm for them has subsided since the early stages of the National Institute of Mental Health community mental health centers movement. There currently is more interest in developing linkages between Department of Mental Health programs and psychiatric units in general hospitals and other non-Department of Mental Health programs rather than continuing the earlier pattern of having all services located in a single building.

   For the most part, existing community mental health centers are operated as Department of Mental Health programs and are staffed by state employees under the direct administrative control of the Department. As such, the centers are subject to many of the administrative difficulties and program encumbrances characteristic of state services. Attempts now are being made in some centers to develop autonomous, community corporations which would contract to replace the Department of Mental Health in administering center programs.

3. **Private Psychiatric Hospitals.** Facilities such as Glenside, Westwood Lodge, McLean, Human Resource Institute, etc. increasingly are being used by patients with third-party payment or private resources. Where such facilities exist as major resources for local communities, Area Boards and staff are encouraged to develop liaisons for planning and program development.

4. **Psychiatric Units in General Hospitals.** These units have rapidly expanded in recent years. Federal statistics indicate that while in 1955, 80 percent of all inpatient care was provided in public institutions, i.e. state and Veterans Administration hospitals, this is now down to 45 percent. Approximately 50 percent of all psychiatric inpatient admissions now occur in psychiatric units in general hospitals. Until 1970,

Massachusetts lagged behind the national trend, but a number of psychiatric units have been opened recently in general hospitals throughout the state. Department of Mental Health area programs have encouraged and supported these units via contract, assignment of personnel, or through National Institute of Mental Health grants as at Union Hospital in Lynn and at Newton-Wellesley Hospital.

There are several advantages for area programs which utilize psychiatric units in general hospitals. These facilities provide coverage through third-party payments, they have readily available neurologic, medical, and X-ray services; and they enjoy greater public acceptance. Duration of stay also tends to be shorter in general hospitals than in other psychiatric facilities. On the other hand, these units tend to be heavily medically oriented in treatment services, and linkage with community agencies is highly variable. Too great encouragement of the "sick" role may increase dependency and decrease patient initiative for independent living. Moreover, general hospital services are expensive with an average per diem cost of over $100. The complex and expensive facilities of a general hospital may not be needed for many patients with so-called functional mental disease, i.e. depression, schizophrenia, neurosis, and personality disorders. These factors must be acknowledged and balanced by area programs in planning for inpatient services.

Program Content

The patient's best interests require that he/she be treated at minimum cost, regardless of whether costs are measured in time lost from work, inconvenience, psychological regression, removal from ordinary habitat, stress on family, or dollars and cents. Inpatient services should be based on the principle that the social and physical environment in which a person is treated is, in itself, an important factor in the success of treatment. In addition to pleasant physical surroundings, clinical programs should emphasize a person's remaining resources rather than deficits. Thus, the inpatient service should strive to keep the client active and involved in therapeutic programs and activities. When inpatient care is deemed necessary, admissions should be coordinated with the procedures of the general hospital or freestanding center, and an acceptable diagnostic process negotiated.

Treatment plans should be designed with clinicians, the client, and members of the client's social network (family, friends, neighbors, employer, etc.) taking responsibility when possible for defining the problem and changing troublesome relationships.

A variety of therapies and activities should be available within an inpatient service, including: individual counseling, group, family, couples, and insight therapy, problem-solving in a social network, genetic counseling, day activities, vocational counseling and training, workshops, behavior therapy programs, recreational and occupational therapy, short-term and long-term psychotherapy, independent living skills, and educational instruction including tutoring and English as a second language. Special care should be taken to match the needs of the client with appropriate interventions.

The patient's treatment plan should be reassessed, at a minimum, one and two weeks after the individual enters the system and monthly thereafter. Efforts should be made to help the individual live independently. An individual entering inpatient care through the general hospital might be moved to an intensive care facility or other community residential program within a short time. Follow-up and continuity of care are extremely important during these transitional times to help individuals manage life problems without being overwhelmed.

Staffing Patterns

Inpatient care is best provided by staff who are sensitive to individuals in crisis, have the ability to listen and empathize, are resourceful, have abilities in problem-solving, are knowledgeable of human services resources, have nonprejudiced attitudes toward the "mentally ill," and are willing to continually reevaluate their work in response to criticism from other staff and patients. These skills can be found in individuals with varied professional backgrounds.

The exact number of staff required in the different kinds of hospital facilities described previously depends upon the size of the facility, and the type and amount of care it provides in the network of services. An area's programs and facilities, in turn, will depend upon the needs of communities and neighborhoods within its boundaries.

Traditional medical and psychiatric settings are utilized most appropriately in the evaluation and treatment of organic disorders and in use of pharmacotherapy. Admission, treatment, discharge planning, and patient records functions should be performed by staff specifically skilled in these activities.

Community volunteers are an important resource to the area inpatient program. The clinical staff of each area facility, as well as the area administrative staff, should be responsible for recruiting volunteers.

Supportive relationships between clients and community neighborhood volunteers are a vital resource for helping persons move from the hospital back into the community. Once clients return to the community, this relationship with a volunteer may prove to be the essential variable in reducing recidivism.

Due to the potential importance of their relationships with clients, volunteers should be offered meaningful roles such as advocates, tutors, program participants and developers, group leaders, etc.

Former patients also can provide skills and support within an inpatient program. These individuals have valuable knowledge of what it means to be an inpatient and should be utilized and respected in the development of treatment plans and programs. They can add much needed support to individuals in crisis and to their social network. Such work also can benefit ex-patients by reassuring them of their self-worth, thus facilitating a smooth transition into community life.

Costs and Income Sources

Within a few years, it is recommended that the Department of Mental Health, with some exceptions, no longer directly provide inpatient services. When hospital care is required and third-party payment is not available, these services generally should be provided by the Department of Mental Health on a contract basis to private psychiatric hospitals or, preferably, psychiatric units in general hospitals. In some areas where local inpatient units already exist, such as at community mental health centers, these could continue to serve their areas as contracted services rather than as direct administrative units of the Department of Mental Health. Until this goal is reached, the vast state funds now allocated to inpatient care could be used to provide services in a transitional period and for the creation of support programs which eventually will become either self-supporting or partially funded through other sources.

Section III. Area Program Administration

The administrative structure of a comprehensive area-based mental health program should facilitate the provision of services described in Section II of this Manual. The design of such an administrative structure is more readily determined when consensus exists about the premises underlying community mental health programs and when relevant parties agree to the administrative functions associated with such enterprises. However, even under these circumstances, some desirable administrative patterns cannot be implemented immediately or even in the future since they would require major changes in existing law or state administrative and fiscal practices. Nevertheless, it is important to delineate the most effective and efficient means of administering area programs in accordance with our premises and conceptual framework since these goals are realizable by the Commonwealth in the near future. Moreover, we believe that the suggested principles are broadly accepted, and most administrative procedures could be implemented by internal reorganization of the Department of Mental Health without major governmental or legal changes.

In keeping with the rationale that greater consensus can be achieved for new administrative structures if the underlying program principles are made explicit, we reiterate two principles fundamental to community mental health programs:

1. Mental health and retardation services should be delivered at the area level through programs designed to serve a specific geographic population. Although an area program may not be able to meet all the service needs of its population, and combining the resources of several areas might be required to provide services for some low incidence-high need groups, the catchment area model still has the best potential for providing services that are readily available to the client, accountable to the population served, and responsive to the community's particular needs.

2. Effective administration of an area program requires that the area be responsible for planning, developing, monitoring, evaluating, and managing its own programs and resources. Each area should set its own priorities,[1] prepare and manage its own budget, reallocate its resources and appropriations as needed, handle its own personnel and payroll, and write and administer its own contracts and agreements.

Implementing these principles will require transferring responsibility for financial and staff transactions from the central to area administration. Although this concentrates considerable responsibility and authority at a decentralized level, in the present system responsibility is so widely diffused while authority is centralized and subject to such extensive checks and balances that any one transaction can require approval by as many as seven levels of government. The existing system, which appears to have developed in part to prevent abuse of power or misuse of funds, has become so cumbersome and dysfunctional as to constitute mismanagement in and of itself. The rational planning and management of resources, therefore, is often impossible and likely more costly than the abuses it was designed to correct. Furthermore, the present diffusion of responsibility has produced a system where accountability is nearly nonexistent, with consequent loss of credibility among both the government and the citizens it is intended to serve.

Adequate checks and balances on the misuse of authority at the area level are attained by the following means:

- Establishing careful cost-accounting and post-audit procedures for each area account;
- Establishing an Area Board with the power to set policy and priorities, approve or disapprove major expenditures, major changes or additions to programs, contracts and agreements (all within appropriations), and hire and fire Area Directors; and
- Establishing procedures within the regional or Central offices for evaluation and monitoring of programs, review of personnel grievances, setting of standards, and regulation and inspection.

Effective administration of comprehensive programs at the community level requires an area office with the capacity to manage its own affairs, including staffing levels that will assure competent clinical direction and the technical expertise to administer sizable budgets with multiple programs and numerous employees. As a corollary to this development, many staff now assigned to the regional and Central offices should be gradually reassigned to Area Offices.

Expanded administrative structures at the area level should not be merely another layer of bureaucracy added to the existing structure. Instead, as appropriate functions and resources of the institutions are transferred gradually into community programs,

[1] W. Hargreaves *et al.* Resource Materials for Community Mental Health Program Evaluation. Part II. Needs Assessment and Planning. San Francisco, California: National Institute of Mental Health, 1974.

the related functions and resources of the regional and Central offices should similarly be transferred to area-level administrators. Accepting the finite resources of the Department of Mental Health, an adequate area-level administrative structure probably could not be achieved without reallocating some of the resources now utilized at other levels.

The goal of administrative flexibility and creativity at the area level requires that the Legislature forego its practice of exercising line item fiscal control over mental health budgets. Administrators incapable of managing programs within prescribed standards of responsibility and accountability should be relieved of their duties; constraining them by excessive controls is an inappropriate solution. Until such time as clear administrative authority is vested at the area level, there are budgetary mechanisms that can be utilized to redeploy resources within an area program. While these are often cumbersome and time-consuming, they should be applied on an interim basis. The following are examples of such administrative mechanisms.

- *Reallocation of unfilled job slots.* Certain positions which are no longer needed can be "traded in" for other job titles. For example, three housekeeping staff slots might be reallocated to two social worker slots, as long as equivalent funds are involved.
- *Personnel reassignments and training.* Staff currently stationed at a hospital location could be reassigned to a community location, if this were a more relevant use of such staff. Inservice training, including thorough orientation, should accompany such transfers.
- *Cooperation among Department of Mental Health institutions.* In a situation where state hospitals are phasing down and some state schools are adding personnel, surplus manpower in hospitals should be given first option on available jobs in the schools.
- *Cooperation among state agencies.* Personnel can be transferred between agencies where specific services are no longer required in one but are necessary in another. Such staff as maintenance, launderers, truck drivers, laborers, etc. now are needed less by the Department of Mental Health. In the fiscal year following the transfer of staff, the Department of Mental Health could reallocate the vacant job block to a more necessary function or to the consultant (03) and contractual (07) accounts.

In addition to these procedures, the Department might also use the contract mechanism for personnel utilization. For example, in contracting with organizations to establish community residences or other community mental health programs, a commitment should be included that job openings would be posted in state hospitals, and that interviews would be offered first to personnel in institutions.

A recent development related to personnel redeployment is the enactment by Congress of Title XX as an amendment to the Social Security Act. This new federal program, which is a 75-25 federal-state matching program, becomes effective October 1, 1975 and provides for a wide variety of social service programs. It includes funds for training staff affected by the deinstitutionalization process since personnel who have worked for many years in an institutional setting will have to make significant adjustments in assuming work responsibilities in the community. Process training as well as skills training will be necessary. Similarly, many community workers face the challenge of modifying negative attitudes toward these new coworkers so that they can function as effective teams.

Area administrative structures will force much more careful specification of the future roles, functions and responsibilities of the Regional and Central Offices than can be stated yet. Although the major focus of this Manual is on area administration, obviously larger questions must soon be confronted. For example, the regional office structure will continue to play an essential role during the transitional period of phasing down institutions and developing comprehensive community programs. However, enlarging the interim structure and functions of regional offices, as is being proposed by some, may vitiate the development of a viable area administration truly capable of managing its own programs. In the future, when the areas are able to provide most essential services at the local level and to provide additional services through contract or agreement between areas, it is clear that the function of a strong regional office would be modified. In resolving the future role of regional offices, it is important to review each one individually since these offices now are at distinctly different levels of development.

No uniform policy is appropriate on the relative effectiveness or efficiency of providing clinical services directly by the Department or through the mechanism of contract for service since this issue is determined best by the individual areas. The extent to which an area program contracts for services, of course, affects its administrative structure. For example, areas that use contracts extensively should include adequate numbers of personnel capable of supervising, inspecting, and enforcing regulations to assure that quality is maintained by contractual service providers. The issue of labor negotiations and union contracts requires careful study since it is closely linked to expanded contractual service arrangements.

The Components of Area Program Administration

The functions performed by an area office can be grouped into six major categories: (1) executive; (2) clinical services administration; (3) business; (4)

community participation; (5) evaluation and data systems; and (6) resource development. The responsibility for and performance of these functions are shared often by more than one staff group, but we have tried to list the functions under the category where major responsibility resides.

Executive

1. Overall Direction of Clinical and Non-Clinical Programs. The Area Director will have ultimate responsibility, authority, and accountability on the area level for directing all area mental health functions. In order to facilitate this responsibility, the Area Director will develop a formal table of organization designating subdivisions of clinical and business functions and their interrelationships. Since the service delivery system varies from area to area, the table of organization need not follow any single prescribed pattern.

2. Program Planning and Identification of Needs. The Area Director will assume responsibility for these functions at the area level. In so doing, a mechanism will be developed by the Area Director for receiving appropriate input from and providing input to the Area Board, other community agencies and groups, and the area program staff.

3. Resource Allocation. The Area Director will have responsibility for allocating financial resources and will do so in consultation with the Area Board.

4. Reporting. The Area Director will be responsible for delivering reports required by and consistent with Department of Mental Health policy. The Area Director will develop a mechanism for assuring the collection of client, staff, and fiscal data, and the preparation of reports appropriate to the Area Board and regional and Central offices.

5. Negotiations with Outside Groups Involving Exchange of Services, Affiliations, Contracts, and Labor Relations. The Area Director will arrange to have appropriate and adequate legal and business consultation, probably supplied by the regional or Central offices, in order that contracts and other negotiations be performed in a thoroughly legal and businesslike manner.

6. Communication and Relations with the Regional and Central Offices of the Department, Executive Office of Human Services, Other State Agencies, and Local Legislators. The Area Director will be responsible for establishing a network of communication with relevant state and federal agencies and legislators to assure coordinated local services.

7. Personnel. The Area Director will be responsible for the hiring and firing of upper level clinical and managerial staff within the area program in line with state and Department of Mental Health policy. All hiring and firing of other area program personnel will similarly require the Area Director's approval. The Area Director shall be responsible for approving role definitions for all area employees, including job descriptions and lines of responsibility.

8. Budget Preparation and Monitoring. The Area Director will assume responsibility for supervising and monitoring the preparation of the area budget in conjunction with the Area Board prior to its formal submission to the Regional and Central Offices.

Clinical Services Administration

1. Overall Responsibility for Clinical Services. The clinical program will be subdivided into units reflecting the program needs and geographic nature of the area. The directors of the clinical components shall be responsible to the Area Director for their clinical decisions. If these services are contracted, the providers shall adhere to Department of Mental Health standards for care, and the program shall be accessible at all times to the Area Director or his/her staff who will monitor the performance of the contract. When the area program utilizes regional or central programs for the care of local citizens, the Area Office shall negotiate the nature of services to be provided at such a facility, the policies regarding entry and exit from the regional or central programs, and the expected rates of utilization.

2. Coordination and Integration of Clinical Services. The heads of the service units of the area program shall meet regularly as clinical administrative teams to review issues arising among them. They will ensure continuity of care and the smooth flow of patients' records, staff, and other resources among the clinical services as needed by the overall program.

3. Planning, Implementation, and Evaluation of Clinical Programs. This function shall be taken on by the clinical administrative teams and the Area Director.

4. Facilitating the Flow of Information Among Clinical Units in the Area Program. Clients shall be admitted to and discharged from the area program in its entirety, not to individual facilities within this program. This will be true for persons admitted to contracted components as well as to those which are directly operated by the state. Clinical information will be available to all program components and clients will be informed of this policy. Confidentiality of information beyond the area program will be protected as stipulated by statute and Department of Mental Health regulations.

5. Client Records' Supervision. Client records' supervision will be undertaken by a registered medical records' librarian, and a uniform system will be developed for the area as a whole. Active records for clients in regional facilities will be on file at the regional facility, but each patient will have an area case number. When the patient is discharged, the file will revert to the area program's medical records' unit for storage and retrieval.

6. Facilitating Communication Among Clinical Units and Non-Clinical Support Units. This will be undertaken by the clinical administrative teams which will be composed of the directors of the clinical components and those involved in nonclinical consultation, education, administration, and planning.

7. Supervising Laboratory Facilities. Laboratory facilities' supervision will be undertaken by the Area Office for services provided by contracted laboratories or local facilities operated by the Massachusetts Department of Mental Health. Where these laboratory facilities are part of a state hospital, they will be accountable to the Regional Mental Health Administrator.

8. Supervising Pharmacy Operations. Pharmacy operations will be supervised by the Area Office. When the pharmacy is located at a regional facility, it will be supervised by the administrator of the facility and its services coordinated for local clients by the Regional Mental Health Administrator and the Area Director. Nonfacility-based pharmacies serving Department of Mental Health clients shall be utilized at the discretion of the Area Office since pharmacy services at the area level may not necessarily be a program component.

9. Planning and Implementation of In-Service Training. The planning and implementation of in-service training efforts will be conducted on an area program basis as determined by staff and local program needs. Each area program shall develop its own in-service training program by utilizing its own personnel or by combining its resources with those of other areas under the leadership of the Regional Mental Health Administrator.

Support Services Administration

1. Personnel Responsibilities. The Area Business Manager shall be delegated administrative authority for personnel action, and he/she will be responsible for maintaining personnel records and preparing the payroll. Whenever possible, this procedure should not require regional and Central office review although records will be sent to the regional and Central offices for information purposes.

2. Budget Preparation. The preparation of the annual budget should be conducted by the appropriate business and management staff at the area level and should contain cost-accounting analyses.

3. Expenditure of Funds and Budgeting Available Resources. The expenditure of funds should be under the administrative control of the Area Office subject to postaudit. Transfer of funds within accounts shall be at the discretion of the Area Director.

4. Writing and Administering Contracts. The Area Office should have legal and business expertise available either through Department of Mental Health staff or through consultation to write appropriate contracts and to monitor their performance. The area should be delegated the authority to commit funds through contracts as it does when hiring personnel; it should be held accountable for the payment of these funds in accord with the contracts. Vouchers should be signed by the Area Director, and countersigning by both the regional and Central offices should not be necessary. Postauditing should be sufficient control on such expenditures.

5. Fiscal Administration of Grants. The business office at the area level is responsible for the fiscal administration of all federal and state grants. It should collect the necessary fiscal and personnel data, keep accurate records of grant-funded positions, and provide the granting agencies with whatever fiscal and accounting information they require to continue funding.

6. Administration of Reproduction Materials and Resource . Each Area Office should have the capacity to maintain and operate a complete communication system, which includes the capacity to reproduce and print documents as needed.

7. Ordering and Dispensing of Supplies. The Area Office should order and dispense supplies to the area program components as appropriate.

8. Maintenance, Housekeeping, and Food Services. Building maintenance, whether direct or under contract, should be supervised by the Area Office when local public buildings are used by the area program. The maintenance of regional facilities such as state hospitals will be under the control of the hospital administrator and the Regional Mental Health Administrator. The same division of responsibility pertains to arranging food for patients in residential treatment, for supplying clothing, laundry, etc.

9. Billing, Collections, and Insurance. Although the Central Office can streamline billing operations, fiscal statements should be submitted to the patient by the Area Office. Similarly, the patient

should negotiate fee adjustments, if necessary, with the Area Office. The Area Business Manager should bill insurance companies, Titles XVIII and XIX, and other third-party payers directly. Collected fees will be paid into the state's General Fund and will not remain locally although they will be credited to the area program account. Accurate area records should be kept, therefore, regarding income generated for services so that fees earned by area program components can be applied to program development. The Department of Mental Health's inability to retain receipts constitutes a significant limitation on the future growth of community programs. Although production records and fees documentation may be useful in some respects, so far they have not resulted in additional dollars from the General Fund. A mechanism should be created which will allow the area program to retain all or part of the income generated by services provided within the area. When fees are billed by private contractors, these fees will be paid to the provider and information regarding such fees will be communicated regularly to the Area Office.

Community Participation

1. Responsibility for Citizen Representation in Decision-Making Process. Area Office staff must have established procedures to ensure citizen representation in all phases of the decision-making process.
2. Communication with Local Community Agencies. Designated Area Office staff should maintain communication with community agencies, visit them, and keep them informed of the activities and services of the mental health system.
3. Coordination and Representation on Various Councils and Boards. Area Office staff should be responsible for liaison with councils and boards in the community and should delegate representatives from the area mental health program.
4. Staffing the Area Board. The Area Director will assign suitable personnel to work with the Area Board and to orient its members on issues and policies. This is vital for the Board to perform its functions to maximal capacity.
5. Liaison with Area Legislators. It is the responsibility of the Area Office to be in close communication with area legislators to inform them of the services provided by the local mental health program, as well as to keep them apprised of local needs and priorities so that the legislators may more effectively represent them.
6. Development of Written Material for Distribution to Community. The Area Office must take responsibility for developing informative written material and disseminating it in the community to promote citizens' knowledge of the mental health services available.
7. Recruitment, Placement, and Supervision of Community Volunteers. The Area Office will establish a mechanism for the recruitment, placement, and supervision of community volunteers.
8. Advocacy. The Area Director and his/her staff must take responsibility for patient and community advocacy with the local government, the media, community agencies, and the community-at-large.

Evaluation and Data Systems

Evaluation is defined as the process of determining the value or degree of success in achieving a predetermined objective. Thus, evaluation efforts must be based upon explicit criteria which can take the form of the goals and objectives established by the Area Board in its annual plan assuming that they are sufficiently detailed. Other criteria can be standards of the American Psychiatric Association, National Institute of Mental Health, accreditation standards of the Joint Commission on the Accreditation of Psychiatric Facilities, or standards established by the Department of Mental Health.

A carefully designed data system must be established if evaluative activity is to take place. At the area level, the data system should be directly integrated with a management information system to allow for differential cost-effectiveness studies. The evaluation data system also must be planned to accept multiple criteria of effectiveness, including measures of citizen and client satisfaction. Models of integrated management and evaluation information systems exist in other states,[1] and several smaller systems are operating now in areas of Massachusetts. These alternative models should be examined thoroughly and compared to the Multi-State Information System currently being utilized and expanded by the Central Office of the Massachusetts Department of Mental Health. While a centralized data system is necessary for state-level fiscal and program accountability, a decentralized system is maximally effective for local management and effectiveness evaluation.

The following types of evaluation are the Area Office's responsibility:

1. Level of Effort of Service Delivery. Area Office staff will be responsible for collecting patient

[1] National Institute of Mental Health. Integrated management information systems for community mental health centers. Department of Health, Education, and Welfare Publication No. (ADM) 75-165. 1974.

utilization statistics which measure the volume of service rendered local citizens. Priority setting by Area Boards and community surveys of expressed mental health needs are factors relevant to determining where, how, and in what volume services should be delivered. Effort evaluation also can occur via monitoring procedures, e.g. patient complaints and various utilization reviews. Level of effort assessments can be initiated before more refined evaluation procedures are in place.

2. Effectiveness of Treatment and Intervention (Service Outcome). Outcome refers to the changes or benefits brought about in clients or communities as a result of the services delivered. Effectiveness studies are more complex than studies of effort and require scientific methodology and rigor; thus, this type of periodic evaluation might be contracted to an outside research organization. As an alternative, the evaluation of effectiveness could be a function of regional level staff. In either event, such studies by parties outside the Area Office help to guarantee the required objectivity. Consumer satisfaction should constitute one dimension of such studies.

3. Efficiency Studies. These evaluation procedures seek to determine the relationship of costs to services and can take a variety of forms. Cost-effectiveness studies can be carried out only where there is a mechanism for cost-finding. Such studies then measure the relative efficiency of different forms of therapy or other clinical services in achieving their stated objectives, e.g. the cost of psychotherapy v. medication in achieving discharge from residential care. Cost-benefit analysis, while still rare in the human services, is a technique which attempts to specify and evaluate the fiscal costs and social benefits of different interventions to help decide which has a greater claim to limited resources. Efficiency studies should be done when possible by area-level staff or by contract since they have a direct relationship to internal operations and management.

4. Adequacy or Program Impact Studies. These studies attempt to determine the number of people affected by a given program in relation to the numbers determined to need such a program. Adequacy studies have direct implications for service delivery so they should be carried out at the area level when possible. However, they also could be performed at the regional level. In either case, contractual mechanisms probably should be utilized.

Resource Development

1. Financial Resources. The Area Office staff will be responsible for determining possible funding sources, public or private, on the local, state, or national level. Area administrative staff should contact granting agencies to be kept informed of available monies and priorities as well as to make arrangements for third-party payments and other types of reimbursements.

   When a source of funds is identified, it is important to match the right program to the resource. This involves identifying the target population and other criteria specified or implied by written or verbal guidelines, maintaining a file on area program priorities, and proposals for submittal when monies appear available. In addition to maintaining a file on program needs and proposals, area personnel responsible for resource development could assist the clinical staff in designing a program that will meet explicit or implicit funding requirements.

   Staff at the area level, with technical assistance from regional and Central office personnel, should be skilled in preparing grant applications and proposals. Relevant skills include clear expository writing, a knowledge of the field's substantive language, and the ability to explain the proposed program within the format of the application's guidelines.

   Staff in the Area Office familiar with federal and state granting procedures should be involved in the grant program startup. Depending on the fiscal administration, these procedures may be simple or complex. As required by the grantor, area administrative staff must be responsible for preparing progress and interim reports. They also must inform the program staff of what clinical and program data and evaluative materials will be required during the granting period.

2. Nonfinancial Resources. A comprehensive area program requires nonfiscal resources as well as fiscal ones. For example, volunteer programs have shown their usefulness in a variety of ways, including task completion and community relations. By utilizing the specialized staff of other agencies, both state and private, Department of Mental Health resources can be extended. A linked system of human services agencies will strengthen the services of each of its component organizations. Many resources exist in the community that are not formally identified with Department of Mental Health programs now but which can become relevant as the Department shifts its principal orientation from hospital-based to community-based services.

Staffing Patterns

Staffing patterns for area offices must be adequate to implement the six major functions outlined in the preceding section. However, since the major thrust of area programming is toward decentralization and

tailoring of structures and services to unique area needs, it is best not to delineate a single area office staffing pattern which would be relevant for the wide variety of existing and future area programs.

Administrative needs necessarily differ with the type of program developed in each area. They are influenced by factors such as affiliations with universities, medical schools or major hospitals, degree of emphasis on the medical or social psychological program model, extent of urbanization and poverty, geographic size, availability of private services, and extent to which an area utilizes contracts vs. direct provision of services. It seems no more sensible to attempt to specify standard administrative staffing patterns for each area than it does to specify uniform clinical staffing patterns. Nevertheless, the following administrative positions are basic and must exist in every area: an area director, a deputy (or associate) area director, a business manager, a data specialist, and adequate secretarial or clerical positions. Beyond this minimum staffing level, additional administrative positions should be created in accordance with the size of the area budget, and the types and complexity of service patterns the area has developed or needs to develop. As the scope of responsibility grows at the local level, area directors will become hard pressed to perform all necessary functions. The role of deputy or associate area director will become increasingly critical, and the current position of Associate Area Director should then be upgraded in functions and salary.

It has been emphasized that area offices are responsible both for the direction of all local clinical programs and for overall management of the area's budget. The nature of clinical administration in areas which have multiple existing services will differ from that in areas whose primary need remains that of developing such services. Supervisory needs also will vary according to the extent to which services are contracted; areas depending heavily on contracted services require personnel qualified to inspect and enforce regulations. Similarly, the nature of area business administration will differ in locales which have many state-operated programs as opposed to those which primarily contract for service, as well as between areas with small as opposed to large budgets.

Since the requirements for clinical and business management in each area will vary widely over time, area administrative personnel beyond the core positions of area director, deputy area director, business manager, and data specialist also could be hired under an annual contract with the Area Board supervised by the Area Director. This procedure would permit the Area Office's staffing pattern constantly to be tailored to the area's clinical needs and to the particular mix of public, private, and contractual services then in force. For example, an area program utilizing numerous state employees requires staff skilled in state personnel procedures. Should the clinical services provided by public employees be shifted to contracted services, an Area Office would then require staff skilled in negotiating and supervising contracts, estimating contract costs, determining legal requirements, and processing vouchers. The need for Area Office staff to handle state personnel transactions would decrease correspondingly. By providing a portion of the area administration's funding in the contractual account, these kinds of changes or additions to area administrative staff can be readily effected. Moreover, when there is a major increase in an area's budget, a contractual arrangement for funding the Area Office permits the rapid addition of personnel needed to supervise new or expanded services. Reductions in direct service budgets or other redistributions of resources similarly could be reflected in a budget decrease for area administration.

When the total area program budget exceeds $2 million annually, additional administrative personnel are required. Specialized staff include a fiscal manager or senior accountant, and a personnel manager. These added support staff are vital since area programs, as part of the state system, deal with multiple levels of a large bureaucracy. The position of personnel manager is becoming increasingly important due to the necessity of implementing affirmative action programs, recruiting indigenous personnel, conducting employee evaluations, and offering career planning assistance.

Costs

Area administration should be funded in relation to the size of the area's program budget, approximating seven to eight percent of the total funds in areas with very large budgets and 10 percent or more in areas with very small budgets. This funding should be provided in a way that permits maximum flexibility in the development of area administrative capacities, either through contracts with each Area Board or through creation of administrative positions which permit the hiring of a wide variety of clinical and management personnel types.

The statewide average for an area budget in Fiscal Year 1976 most likely will be at a minimum $1,500,000. A projected cost per area office of $150,000 or about 10 percent of the budget's total is consistent with this minimal funding level for area programs. Since no administration should be funded at less than $150,000 annually, the percentage of an area's total budget devoted to administration could be higher than 10 percent in those areas with the smallest budgets. However, this basic administrative staff is necessary to assist such areas in developing the essential services they require. On the other hand, areas with very large program budgets probably will require somewhat less than 10 percent

of their total expenditure for administration.

Administrative resources from phased-down state hospitals as well as from the Central Office could be reallocated to achieve area-level managerial capability. The projections contained in Table 3-1 are based on data derived from the Department of Mental Health Fiscal Year 1975 budget. Precise data for Fiscal Year 1976 are being prepared. State hospital funds tentatively reallocated to area budgets are included in overall area totals. The data are presented only to illustrate the range of area budgets in relation to administrative costs. The influence on administrative costs of such factors as federal funding and other revenue sources with unique fiscal reporting requirements is not included.

Table 3-1. Suggested Sample Budgets for Core Area Administrative Staff

Area	Fiscal Year 1975 Total Available Funds[1]	Recommended Minimum Area Office Budget	Recommended Supplementary Staffing Funds	Recommended Total Area Office Budget	Percent of Total Area Budget[2]
Eastern Middlesex	$ 976,000	$150,000	$ 0	$150,000	15
Blackstone Valley	2,121,000	150,000	38,190	188,190	9
Fall River	3,329,000	150,000	116,320	266,320	8
Massachusetts Mental Health Center	5,912,000	150,000	263,840	413,840	7

[1] Includes state, federal, and local funds available for mental health services. Includes projected reallocation of state hospital resources to area programs. Does not include Department of Mental Health funding for retardation. Does not include 6.2 percent cost-of-living salary increase which affects 80 percent of personnel account.

[2] The sliding scale percentage of area administrative costs is based on the total area office budget in relation to an area's total available funds.

Section IV. Implementing Community Mental Health Programs

The previous parts of this Manual have reviewed the eight services considered integral to each catchment area's comprehensive program. Although every service has unique clinical characteristics, staffing requirements, cost considerations, etc., they also are closely linked and interdependent. In fact, when a composite of all eight basic services is arranged on these dimensions, certain trends and program directions become quite evident. Section IV analyzes these trends in relation to the implementation issues at the area and state levels so that persons responsible for area program development can have a broader appreciation for the factors facilitating or impeding the achievement of locally established goals and objectives.

Organizational Auspices

Community mental health programs are best administered within an organizational framework which encourages innovative and diverse approaches to the design and delivery of services. In Massachusetts, the Department of Mental Health has been the major provider of services, and it operates within the guidelines and requirements of state government. Many innovative and pioneering services have emerged from these publicly operated programs. Yet, the feeling is widespread that governmental constraints significantly restrict even further advances. For example, the "anti-aid" Amendment to the Massachusetts Constitution[1] bars direct grants in aid to nongovernmental organizations.

In reaction to other artificial and severe administrative impediments within the public sector, the Department of Mental Health, therefore, now is giving increased attention to the alternative of contracts with voluntary and private agencies. Massachusetts government has long used the contracting mechanism for such human services as alcoholism and rehabilitation; more recently, services have been contracted for drug addicts and juvenile offenders as well.

Contracting has many distinct advantages, including budgetary control and flexibility. A fundamental but seldom recognized advantage is that it protects the public administrator from the conflict of interest created in both administering and monitoring one's own program. A second advantage is that contracts can be terminated or modified at set intervals in contrast to the constraints imposed upon program change when programs are operated by Civil Service employees, particularly in publicly owned buildings. A further advantage of the contractual approach is that nonpublic agencies can bill third-party sources and retain the receipts for direct use in mental health programs. This capability contrasts with the practice of the Department of Mental Health whose receipts from third-party payments now go directly to the Commonwealth's General Fund. Each year, millions of dollars are reimbursed for mental health services provided to citizens in Massachusetts. A system must be designed to earmark at least the majority of these funds for mental health services to allow continued growth of community-based care.

In order to achieve maximum benefit from varied funding sources, Area Boards should decide which components of their total program can best be contracted, which should be provided through Department of Mental Health staff, and which provided by a combination of contractual and public staff. Program capability varies considerably from area to area, and local Citizen Boards know best the strengths and weaknesses of their own public and nonpublic agencies. Greater balance between publicly and contractually provided services is needed at this time if further innovation and program effectiveness are to occur. The specific patterns for achieving this balance should be determined locally.

Distinctions are difficult to make among the many combinations of contracts and agreements that are possible between a service organization and the public agency. We propose four types reflecting patterns in Massachusetts and other states.

1. **Fee-for-Service.**
   - The service organization bills the public agency who, in turn, may or may not bill the client or third-party payer.
2. **Fixed fee.**
   - The service organization bills the public agency at a *fixed fee* per calendar period regardless of volume of services provided to clients.
   - The service organization bills the public agency at a *fixed rate* or *percent* per calendar period based on a variable such as staff hours expended, percentage of bed occupancy, or other indirect service indicators.
   - The public agency pays the service organization a *lump-sum*, one-time payment for the performance of services.
3. **Dual resource utilization.**
   - The public agency pays salaries and/or

[1] Massachusetts Constitution, Articles of Amendment, No. 46, Sections 2 and 3

operating expenses for work performed by service organization personnel at the service organization's site.
- The public agency's own staff, equipment, and/or materials are authorized for work or use at the service organization's site.

4. **Mutual interest affiliations.**
   - The service organization and the public agency, in consortium, receive operating or capital construction monies from a common funding agency (e.g. National Institute of Mental Health) based on an agreement to cooperate in their mutual use.
   - The service organization and the public agency share salaries and other operating or capital expenses to perform work of benefit to each or to mutual clients.

The Department of Mental Health must develop a simplified and consistent system for contracting services if it is to achieve substantial movement in the direction of program flexibility. The Department's increased capability should be built upon the experiences of other state agencies in the contracting process. In particular, the roles and responsibilities of central, regional and area staff as well as the Area Board must be clarified to avoid long delays in the negotiating and reimbursement phases.

Program Components

A primary goal of this Manual is to shift community mental health programs away from their excessive reliance on hospital care to greater utilization of ambulatory services. Such alternative interventions as consultation and education, emergency, and outpatient services come much closer to meeting client needs at critical points in time, they reduce client dependency, and they are more economical. Day/evening treatment services, social rehabilitation, vocational rehabilitation, and community residences are similarly less expensive to operate and more clinically effective for many clients than is inpatient care. As programs expand at the local level and clinicians and citizens become increasingly sophisticated about alternatives to hospitalization, inpatient care should be viewed as a last resort rather than as a treatment of choice.

As a guide to those planning and administering comprehensive area programs, Table 4-1 lists the more than 70 clinical, administrative and support functions[1] integral to these programs. The table suggests that some system functions such as information and referral, record storage and retrieval, and volunteer training always should be included in each of the basic services. Other functions such as the dispensing and supervising of medication, research, and laundry should be included in some services but not others. Since this Manual focuses upon the direct services provided clients, training and research are listed simply as two of the community mental health program's 72 system functions. In major academic and research centers, these two functions obviously assume much more centrality—perhaps even overshadowing clinical ones.

Many of the system functions could be performed by varying combinations of one, two, or more of the basic services. Each catchment area should assign the system functions according to local circumstances, thus producing a program maximally relevant to local needs.

A corollary goal of this Manual is to emphasize explicitly that the needs of emotionally troubled persons require interventions from a wide network of human services caregivers. The Department of Mental Health through its clinical facilities cannot alone provide the full array of human services needed by its clients. Consequently, mental health agencies must establish strong, routinized working relationships with other caregivers in the human services system. These linkages should, through contract or other types of agreement, provide mental health agency clients with the technical skills and resources already available in other agencies—they need not be duplicated.

Continued Program Development

The past decade's progress in developing community mental health programs will not be sustained unless ever-emerging problems are resolved. Among the problems looming most prominently over the next several years are the following:

1. **Community Relations.** Local opposition and resistance to neighborhood residences sometimes have been formidable. Educational projects, expanded volunteer recruitment campaigns, public information materials in printed and audio-visual forms, and other such activities must become a priority of the comprehensive program. Increased public understanding is a vital prerequisite for the Department's continued movement into the community. Large numbers of citizens must become involved in activities of this type if there is to be any reasonable chance of program success.

2. **Economic Effect of Hospital Phase Down.** In cities and towns where hospitals are located, much concern arises about the adverse effects of phase down upon the local economy.

[1] The list of functions was compiled by James Gorman, Director of the Massachusetts Department of Mental Health's Manpower Reclassification Project.

However, studies in California[1] have demonstrated that the local economy does not suffer and may even gain. Careful planning is overdue on alternative uses for no longer needed institutional land and physical plants, including full or partial razing of outdated buildings.

3. **Staff Redeployment.** Absolute growth in the Department's budget as well as in those of other human services agencies will be limited during the foreseeable future in view of the dim economic climate in Massachusetts as well as in the nation as a whole. This fiscal reality makes it imperative that the Executive and Legislative Branches of Massachusetts Government establish efficient and flexible procedures for alternative deployment of present Civil Service employees. Professional disciplines, unions, and other groups have aggregated a degree of influence over policy-making over the years. Such groups will have to be briefed thoroughly in the policy changes occurring over the next few years, with a particular view to the potential impact on paid positions and employee utilization. Redeployment often will require retraining, and the Department of Mental Health should make a substantial commitment to this effort.

4. **Department of Mental Health Administrative Structure.** Significant steps are being taken to decentralize certain functions such as program administration from the Central to the regional offices. A fundamental premise of this Manual is that decentralization must continue to the area level as well so that program directors will have administrative powers commensurate with the responsibilities assigned them. On the other hand, area program administration is facilitated by standards, accountability mechanisms, and quality control procedures established by the Central Office.

5. **Catchment Area Size.** Federal authorities in 1965 required that a catchment area have no less than 75,000 and no more than 200,000 people to most effectively provide and support the essential community services. While this range was accepted for nearly ten years as the feasible size of a population base, some programs now have begun to design services for a population base of only 10-15,000 people. In fact, this subarea or neighborhood approach is integral to some of the models described in Section II of this Manual. On the other hand, certain services designed for relatively small client groups could be offered only through geographic constellations larger than single areas. A region should be the operational unit when practical; when this is not practical, a combination of areas should serve as the geographic base.

6. **Transportation.** The accessibility of services depends on public transportation where private automobiles are not available. Since a public transit network currently does not operate in many suburban and rural areas, many Department of Mental Health services are out of reach to people who cannot make private arrangements. Limited income people are particularly affected. The Department of Mental Health should initiate planning for a human services transportation system in cooperation with the Executive Office of Human Services and other state agencies. The focus should be on facilitating transportation for people needing several human services at different times and places. This is not an easy problem to solve but the need is common to many agencies. In fact, some federal funds are available now for such purposes.

Clients and Their Families

Consumer participation has had a major impact upon the human services during the past decade. Not only are citizens involved in policy making roles through Area Boards and similar bodies, the lawyers of clients now have access to heretofore confidential records and they are more knowledgeable about diagnostic and treatment processes. Furthermore, the rights of clients are increasingly being determined in the Judicial and Legislative Branches of Government rather than within the Executive or Administrative Branches as had been true previously. For example, the Mental Health Legal Advisors Committee, established by Massachusetts General Laws Chapter 221, was appointed in 1974 by the Massachusetts Supreme Judicial Court to provide legal assistance to the indigent mentally ill. It is entirely consistent with the spirit of this law and similar legislation now being enacted throughout the country that clients of the mental health system be explicitly informed of their civil rights and treatment prerogatives.[2] Mentally ill persons are highly vulnerable to the whims and dictates of caregivers and safeguards must be established to insure that even well-intentioned but destructive actions are not directed against them.

The rights of clients served by the Department of Mental Health can be guaranteed only by systematic efforts on the part of many persons in the agency. The "civil rights officer" approach thus far has been of limited effectiveness but possibly can be made to work with the deployment of more resources. Civil rights officers (or client advocates) should be ad-

[1] Stanford Research Institute, Process and impacts of the closing of DeWitt State Hospital, June, 1973.

[2] *Your Rights As A Mental Patient In Massachusetts: A Handbook for Patients by Expatients*, Legal Project/Mental Patient Liberation Front, 1974.

Table 4-1. The System Functions of a Community Mental Health Program

System Functions	Basic Clinical Services								
	Admin-istration	Hospital-ization	Ambu-latory	Emer-gency	Day Hospital	Consulta-tion & Education	Com-munity Resi-dences	Voca-tional Rehabili-tation	Social Rehabili-tation
1. Reception/Initial Assessment		X	X	X	X		X	X	X
2. Crisis Response/Coverage		X	X	X	X				
3. Monitoring Community Events	X		X			X	X	X	X
4. Client Outreach		X	X		X			X	X
5. Service Eligibility Processing	X	X	X	X	X			X	X
6. Information and Referral	X	X	X	X	X	X	X	X	X
7. Intense Assessment/Diagnosis/ Testing (inc. vocational)		X	X	X	X			X	
8. Case Planning/Review		X	X	X	X		X	X	X
9. Integration of Services for Client	X	X	X	X	X	X	X	X	X
10. Record Storage/Retrieval	X	X	X	X	X	X	X	X	X
11. Follow-up		X	X	X	X		X	X	X
12. Emergency Treatment		X	X	X					
13. Dispensing/Supervising Medication		X	X	X	X				
14. Community Crisis Service			X	X					
15. Therapy to Clients		X	X	X	X		X	X	X
16. Counseling Significant Others		X	X	X	X		X	X	
17. Job Counseling		X	X		X		X	X	
18. Recreation/Socializing		X			X		X		X
19. Job Placement					X			X	
20. Foster Home Placement		X							
21. Client Training for Physical Self-Care		X			X		X		X
22. Educational Planning	X	X	X		X	X	X	X	X
23. Companionship		X			X		X		X
24. Surveillance		X							
25. Detoxification		X		X					
26. Medical Care Provision		X		X	X				
27. Physical Care Provision		X							
28. Dental Care Provision		X	X		X				
29. Case Consultation		X	X	X	X	X	X	X	X
30. Program Consultation	X					X	X	X	X
31. Education (Community Relations)	X					X	X		
32. Education (Prevention)	X					X			
33. Training of Staff of Other Agencies		X	X	X	X	X	X	X	X
34. Vocational Training								X	
35. Rehabilitation/Resocialization		X			X		X	X	X

System Functions	Basic Clinical Services								
	Admin-istration	Hospitali-zation	Ambu-latory	Emer-gency	Day Hospital	Consulta-tion & Education	Com-munity Resi-dences	Voca-tional Rehabili-tation	Social Rehabili-tation
36. Primary Prevention Services						X			
37. Program Evaluation	X								
38. Research	X	X	X			X			
39. Evaluation of Staff Performance	X	X	X	X	X	X	X	X	X
40. Client and System Advocacy Brokerage	X	X	X	X	X	X	X	X	X
41. Development of Community Resources	X					X			
42. Coordination of Community Resources	X					X	X	X	
43. Collaboration/Liaison with Community Groups/Agencies	X	X	X	X	X	X	X	X	X
44. Liaison with Area Board	X					X			
45. Coordination of Area Program Units	X								
46. Resource Allocation	X					X			
47. Planning	X								
48. Fiscal/Budget Preparation, Planning and Management	X								
49 Staff Hiring, Firing, Assignment	X								
50. Policy-Making	X								
51. Public Relations	X								
52. Typing/Clerical	X	X	X	X	X	X	X	X	X
53. Billing	X	X	X	X	X	X	X	X	X
54. Payroll	X								
55. Contract Writing/Monitoring	X								
56. Reporting to Federal/State Agency	X								
57. Fund Finding	X								
58. Design of Orientation/ Training Programs	X								
59. Personnel Training	X								
60. Volunteer Training	X	X	X	X	X	X	X	X	X
61. Data Management	X	X	X	X	X		X	X	X
62. Inspection and Licensing	X								
63. Transportation Services				X	X				
64. Repairs of Facilities and Equipment	X								
65. Janitorial Services	X	X		X	X		X	X	X
66. Grounds Maintenance	X								
67. Security	X	X							
68. Food Service		X			X		X		
69. Laundry Service		X					X		
70. Pharmacy Service		X		X	X				
71. Laboratory Service		X		X					
72. Printing/Reproduction Service	X							X	X

ministratively independent of the clinical unit to which they are assigned to avoid conflict of interest situations. Specialized paralegal training should be provided all staff assigned to protect clients' rights, and an outside group or organization, e.g. the Mental Health Legal Advisors Committee, should monitor such activities on behalf of clients.

The participation of clients and their families in treatment planning, activities, and decision-making is not only a matter of right, it is good treatment practice. Clients must assume active responsibility for their own lives. Along with the right to participate in treatment decisions, clients also should be apprised of the fact that their legal counsel has access to personal clinical records. They also should recognize, however, that information necessarily is shared among the several clinical services comprising the area program so as to enhance continuity of care.

Staffing Patterns

Expansion of the full range of community mental health services detailed in Section II has profound implications for the present pattern of resource deployment. As was evident in Table 1-2 and in the following Table 4-2, the vast majority of public mental health funds currently are expended for adult 24-hour care. In a typical area mental health budget, 67 percent of the funds in Fiscal Year 1974 were allocated for the staffing of adult inpatient services.

Due to present fiscal stringencies, some of these resources must be shifted to ambulatory care, emergency services, community residences, etc. if clinical alternatives are to flourish. Unfortunately, however, the Department has been severely hampered in its efforts to efficiently deploy staff and other allocated resources by the superabundant layers of checks and balances in the state system. Certain common personnel transactions involve the following state agencies: Administration and Finance, Personnel and Standardization, Treasurer's Office, and Civil Service Commission. There are also instances where legislative committees participate in administrative matters. Continuation of a system which significantly hampers the decision-making process merely will delay the changes which so many agree must be made.

Personnel reallocations inevitably create doubt and anxiety about job security. The shifting of present personnel, therefore, must proceed in a carefully delineated manner. The Department of Mental Health's effort to reclassify positions in relation to functional job descriptions is a meaningful building block in this process. Personnel transferred to different functions and responsibilities should be enrolled in training programs teaching the basic skills needed to perform new jobs. Specialized training packages are developed and presented most effectively by Central Office staff, but all community program administrators must assume responsibility for the ongoing training needs of area staff. Area Directors should define a minimum to maximum number of weekly in-service training hours to insure necessary skill development; Area Boards should support the use of staff time for training purposes.

The Department of Mental Health has explicitly acknowledged responsibilities to current employees as it phases down large institutions. Labor unions must similarly acknowledge that shifting program emphases inevitably will lead to new job functions for affected employees. The transition will be facilitated if functional skills are emphasized in reassigning staff; academic credentials and professional affiliations should receive less emphasis in assessing staff ability to perform new functions.

The realigning of functional job descriptions in keeping with present operating practices could particularly affect psychiatrists for whom present statutes and regulations reserve a number of functions. For example, all medical-legal determinations now are assigned by statute to qualified physicians who are in relatively short supply in the public sector. Out of necessity, many such decisions presently are being made by other mental health professionals. Knowledgeable observers, therefore, are questioning whether this statute should be altered so as to reflect present practices. Many other community mental health clinical and administrative functions require expertise that can be gained through training and on the job experience by a variety of human services disciplines. The operating principle, then, should be that leadership positions are to be filled only by persons with demonstrated skills relevant to the requisite job functions. Neither physicians nor other professional groups should be assigned leadership by virtue of credentials per se. Unfortunately, the antiquated "medical leadership model" still is used by many third-party payers for standard setting; and, thus, it has negative fiscal implications in addition to adverse morale ones.

Although community mental health programs have provided significantly expanded job opportunities for white male professionals, women and minority group members have benefited less. They continue to be underrepresented in various geographic locations and in various leadership positions. Equal opportunity and affirmative action programs must be pursued aggressively to rectify this situation where it exists. The applicable principle is that staffing patterns in a given setting should reflect the composition of the population being served. Thus, women should fill one half of the staff positions when possible, and minority group professionals should be assigned key responsibilities in communities with a sizable minority group population.

Two other groups possessing relevant skills but un-

derrepresented in present staffing patterns are former psychiatric patients and volunteers. By using those former patients who display empathy and sensitivity as training staff, civil rights officers, emergency-team members, rehabilitation counsellors, etc., constructive applications can be made of the skills and experiences gained by these persons. Legal, ethical, and therapeutic concerns associated with the employment of former patients need to be carefully worked through; blanket policies forbidding the hiring of former patients should be eliminated. Obviously, meaningful training opportunities should be provided for such new employees as are provided other persons assuming new job responsibilities.

Volunteers have long been part of the mental health scene and yet their skills generally are utilized in a less than optimal manner. In recent years, some programs have begun using volunteers for treatment as well as supportive roles. Volunteers not only supplement staff but they also provide communication links with the larger community, thus helping to promote greater understanding of mental health programs. However, volunteers should not be assigned duties currently performed by paid employees or in any way utilized to undercut staff job security. In a period of recession, particular care must be taken to insure that volunteers are not viewed by organized labor as a threat to existing paid positions.

Facilities

The community mental health services described in Section II should be provided through accessible, decentralized facilities convenient to the populations seeking help. Thus, most spaace requirements should be planned on a far smaller scale than had been the pattern during the 1960s. The construction of large, publicly owned facilities is antithetical to current program philosophy in that it centralizes rather than decentralizes service delivery while generating disproportionately high maintenance costs. Furthermore, integrating mental health care within the larger human services system implies the sharing of facilities with other agencies when at all feasible. Inpatient care, for example, preferably should be provided through a community's general hospital rather than constructing a free-standing publicly operated inpatient center. Facilities of the latter type should be used for general human services purposes.

The growing use of alternatives to inpatient care, particularly community residences for those needing short or long-term shelter, has already significantly diminished the need for state hospital facilities. Buildings that are in good physical condition could be used for appropriate mental health purposes or made available for other human services. However, buildings unfit for use should be razed to avoid continuing maintenance costs and to insure against their being used inappropriately at a future time. In many instances, it has been far more costly to renovate deteriorating facilities than to construct new ones.

Costs

Determining the costs of a comprehensive mental health program incorporating the eight basic services described in Section II is vital for budget projections at the area and state levels. Since few, if any, such comprehensive programs yet exist in Massachusetts or elsewhere, fiscal data must be gathered carefully as these services develop. In the absence of such data, tentative projections can be made on the basis of information available from Department of Mental Health Fiscal Year 1974 allocations. It is clear from Table 4-2 that area budgets already average approximately $2 million, and that costs will grow with program expansion and inflationary tendencies. Thus, the delivery of services through community-based, decentralized facilities should not be viewed as generating fiscal savings. Rather, such a delivery system is designed to increase efficiency and effectiveness by providing timely care which reduces subsequent client dependency and debilitation.

Income Sources

The funds necessary to support a comprehensive community mental health program may be obtained from any combination of sources including the following principal ones: Federal government (staffing grants); state government; local government; and reimbursements (patient fees, Medicare, Medicaid, insurance, etc.). The Massachusetts Department of Mental Health in 1974 initiated efforts to clarify for the first time the multiple income sources supporting the state's mental health programs. Data assembled from program administrators throughout the state are presented selectively in Table 4-3 to illustrate the range of per capita income generated in Fiscal Year 1975 from public and other sources. The data from areas with the highest, average, and lowest per capita income highlight substantial funding differences. Department of Mental Health per capita support ranges from a low of $5.37 in Eastern Middlesex to a high of $19.82 in the Boston University area. This disparity must be interpreted, however, in relation to an area's mental illness rates, special population needs, socio-economic character and legislative actions unrelated to needs and resources.

National Institute of Mental Health. Cost-finding and rate-setting for community mental health centers. Department of Health, Education, and Welfare Publication No. (HSM) 73-9069. U.S. Government Printing Office, Washington, D.C.

Table 4-2. Estimated Mean Area Mental Health Budget Fiscal Year 1974[1]: Department of Mental Health Allocations

Target Group/Service[2,3]	Amount		Percent	
Adults				
Inpatient[4]	$ 1,245,000		67.1	
Outpatient	176,000		9.5	
Partial Hospitalization	41,000		2.2	
Community Residences	10,000		.5	
Emergency Crisis Care	21,000		1.1	
Consultation & Education	47,000		2.5	
Other[5]	111,000		6.0	
Subtotal		$ 1,651,000		89.0
Children		173,000		9.0
Legal Medicine		32,000		2.0
Total		$ 1,856,000		100.0

A further perspective on income sources is provided in the National Institute of Mental Health 1972 Community Mental Health Center Profile Package.[6] The National Institute of Mental Health analysis of income sources utilized by the 10 community mental health centers then existing in Massachusetts made it clear that state government funds represent a disproportionately high revenue source here; mental health centers in other states derive proportionately more of their income from federal staffing grants and local government. Furthermmore, reimbursements from patient fees and third-party payments are low not only in Massachusetts but in other states as well. Nationally, income from third-party insurance averages 7.6 percent; but in Massachusetts it is only 2.3 percent. Income from Medicaid nationally averages 5.8 percent yet in Massachusetts it is 1.4 percent. Nationally, income from patient fees is four percent while in Massachusetts it is 0.6 percent.[7] Furthermore, in Massachusetts virtually no income is derived yet from federal General Revenue Sharing Funds for any human services including mental health.

A variety of steps have been taken in this state to diversify funding so that state government need not assume such a heavy share of mental health program funding. A number of catchment areas have applied for and received federal staffing grants for adult and/or children's services although we are still below the national average in this regard. (Since this support is time limited, its temporary nature must be considered.) Efforts at generating additional third-party reimbursements also have been significant and now are stressed by the National Institute of Mental Health.

The following is a partial listing of major third-party funding sources:[8]

1. **Medicare** (Title XVIII of the Social Security Act for those over age 65). Hospital insurance provides partial coverage for inpatient care in a general hospital, psychiatric hospital, or an extended care facility up to an annual nominal limit. Mental illness is discriminated against compared to other diagnoses. Supplementary medical insurance covers physicians' services for inpatient care.
2. **Medicaid** (Title XIX of the Social Security Act for children and those over 65 whose Medicare benefits have been terminated). Ambulatory

[1] Based upon data assembled by Mark McGrath, Special Executive Assistant to the Commissioner, Massachusetts Department of Mental Health.

[2] Does not include retardation services.

[3] Administrative costs are distributed on a prorated basis among the services.

[4] Includes positions at state hospital unit serving area.

[5] Unfilled positions.

[6] Survey of State and Regional Data, Federally Funded Community Mental Health Centers of 1972. Survey and Reports Branch, Division of Biometry, National Institute of Mental Health. June 1974.

[7] Report of the Special Senate Committee on Mental Hospital Accreditation, Commonwealth of Massachusetts, January, 1975. P. 10.

[8] National Institute of Mental Health. Multiple source funding and management of community mental health facilities. Department of Health, Education, and Welfare Publication No. (HSM) 73-9055.

Table 4-3. Fiscal Year 1975 Appropriations for Mental Health: Selected Services and Per Capita Fiscal Analyses for Nine Areas[1]

Catchment Area	DMH State Hospitals (01-02)[2] (in $ 000's)	DMH Community Services[3] (in $ 000's)	DMH Per Capita[4]	Other[5] (in $ 000's)	Total[6] (in $ 000's)	Total Per Capita[7]
1. Bay Cove (Tufts)	$ 504	$ 790	$ 17.90	$ 1,811	$ 3,368	$ 38.71
2. Boston University	737	389	19.82	1,761	4,060	35.00
3. Cambridge-Somerville	2,083	459	17.52	2,310	5,621	29.74
19. Newton-Wellesley-Weston	822	332	9.27	947	2,152	16.55
20. Blackstone Valley	891	243	15.76	86	2,121	16.44
21. Franklin-Hampshire	1,115	215	10.51	792	2 211	16.38
37. Tri-City	1,314	212	9.71	147	1,730	10.61
38. Danvers-Salem	963	264	9.06	97	1,366	9.76
39. Eastern Middlesex	362	144	5 37	369	976	8.64

services to Medicaid clients are reimbursable when provided by approved staff in certified mental health clinics. Inpatient services to Medicaid clients also are reimbursable. Coverage is similar to any health diagnosis.

3. **CHAMPUS** (Civilian Health and Medical Program of the Uniformed Services). A broad insurance program is provided active and retired members of the uniformed services and their dependents, including outpatient care.

4. **Federal Employee Health Benefit Program.** Mental health benefits, including outpatient care, are provided federal employees as part of this substantial insurance coverage.

5. **Private and Commercial Insurers.** A number of private insurance plans for many years have included optional mental health benefits. (About two-thirds of hospital insurance coverage includes some coverage for mental illness.) Effective January 1, 1976 all private and commercial insurance carriers will be required by Massachusetts legislative statute to provide psychiatric benefits to medical and surgical insurance policy-holders. Benefits will include up to $500 annually in outpatient care. Similar requirements for alcoholism also will go into effect on the same date. Since Blue Cross/Blue Shield is the major insurer of Massachusetts residents, this change could significantly increase third-party revenues.

6. **Title XX of the Social Security Act.** This Act provides for grants to states for services. Recipients of income maintenance payments provided under both Title IV-A (Aid to Families with Dependent Children) and Title XV. (Supplementary Security Income for aged, blind, and disabled individuals) as well as persons who meet an income test are now eligible for a wide range of social services. Program categories include counseling and protective services to help improve independent functioning and enrich social relationships, homemaker services to prevent family disruption, services to the mentally retarded and their families making them capable of self-support and independent living, rehabilitative services, etc. In certain instances services can be pro-

[1] Data excerpted from Massachusetts Department of Mental Health Memorandum prepared by William Goldman, M.D. and Mark McGrath, March 18, 1975, "Per Capita Fiscal Analysis of Actual Area and Regional Expenditures for Fiscal Year 1974 and Appropriations for Fiscal Year 1975 for mental health services."

[2] Department of Mental Health. Money from state hospital (01-02): Department of Mental Health money from state hospital, combined salaries of permanent and temporary positions.

[3] Department of Mental Health. Money from 5 x 21: Department of Mental Health money appropriated for community services.

[4] Department of Mental Health Per capita. Includes not only funds for state hospitals and community services but also Drug Rehabilitation contracts, 314(D) awards, and Central Office training grants.

[5] Other. Includes all federal money awarded to mental health facilities or programs in an area; all town or city money as well as private contributions, fees, community partnership matches, etc.; and, all other state money or money collected by state agencies to Department of Mental Health in an area, i.e. Department of Public Welfare, Department of Public Health, LEAA, Office For Children, etc.

[6] Total money. All department of Mental Health, federal, other state, local, and private money.

[7] Total money per capita. Per capita by area of all Department of Mental Health federal, other state, local and private money.

vided the extended family when the services are integral to the treatment plan and directly assist the patient.

7. **Other Revenue Sources.** Additional revenue sources used by agencies include patient fees, income from investments, contributions, support from United Ways and foundations, membership dues, rental fees, fees for services and research and training grants. The broad range of alternative funding sources is available more readily to voluntary nonprofit than public or profit-making organizations.

Even when available, the growing volume of nonpublic "reimbursement" dollars is not fully utilizable by public mental health programs. Current administrative practice requires that such monies be returned to the state's General Fund rather than being retained by the Department of Mental Health; repeated efforts to modify this policy have been unsuccessful. Although the Department's documentation of dollars reimbursed to the state for inpatient services has permitted some expansion of such programs, documentation is still weak regarding reimbursements received for ambulatory and day/evening treatment services.

Another issue associated with the collection of third-party reimbursement is the frequent requirement by insurance carriers that prescribed staffing standards and clinical practices be maintained even though program directors may deem them inappropriate. For example, there is much controversy as to whether referral and regular supervision by a physician is always clinically necessary, or whether it simply constitutes professional "featherbedding." There is increasing agreement that physicians need not supervise all cases; to require it unnecessarily inflates treatment costs. Programs anticipating significant funding through third-party reimbursements should, nevertheless, be familiar with criteria established by the Joint Commission on Hospital Accreditation. They now cover alcoholism and retardation programs and intermediate care facilities as well.

Finally, it should be recognized that in the near future the most likely source of funding for nontraditional, nonhealth community residences and other transitional services are state appropriations to the Department of Mental Health. In general, however, since total public funding is likely to grow at a minimal rate through the remainder of this decade, it is imperative that existing funds be redeployed for these purposes to the maximal degree possible. Almost the only mental health funding source relevant for this use is the category of adult inpatient allocations, and such redeployment already is being suggested by the Department in its budget for Fiscal Year 1976.

Appendix. Task Force on Community Mental Health Program Components

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James M. Pisciotta, A.C.S.W.	United Community Planning Corporation
Donald Taylor, M.S.S.S.	Boston University Area Mental Health and Retardation Program

Committee on Community Residences, Social Rehabilitation, and Vocational Rehabilitation

Convener: Richard D. Budson, M.D.	McLean Hospital
Emily M. Barclay, M.P.H.	Massachusetts Department of Mental Health
Tema G. Carter, Ph.D.	Northeastern University
Sterling I. Colten, Ed.D.	Taunton State Hospital

Jerry Cowan, M.D.	Liberty Street Associates
Margaret J. Dwinell, M.S.S.S.	Center Club
Beverly H. Paoli, M.A.	Rutland Corner House
Gary D. Joslow, M.Ed.	Erich Lindemann Mental Health Center
Mandy Martin, B.A.	Massachusetts Rehabilitation Commission
Dennis McCrory, M.D.	Massachusetts Rehabilitation Commission
Eugene Nigro, A.C.S.W.	Massachusetts Department of Mental Health
Jessie Sargent	Dover, Massachusetts
Robert Schueler, B.A.	Erich Lindemann Mental Health Center

Committee on Consultation and Education

Convener:	Herbert C. Schulberg, Ph.D.	United Community Planning Corporation
Raquel E. Cohen, M.D.		Harvard Medical School
Sandra Rasmussen, Ph.D.		Massachusetts Department of Mental Health

Committee on Day/Evening Treatment

Convener:	Austin Lawrence, A.C.S.W.	Masschusetts Department of Mental Health
Leland Bradbard, Ph.D.		Veterans Administration Outpatient Clinic, Boston
Stanley Rosenzweig, Ph.D.		Veterans Administration Outpatient Clinic, Boston
Richard Stratton, M.S.W.		Worcester State Hospital
Alice Stueks, R.N., M.S.		Massachusetts Department of Mental Health
Patricia Warsaw, R.N.		Erich Lindemann Mental Health Center

Committee on Emergency Services

Convener:	Katherine Dyer, A.C.S.W.	Massachusetts Department of Mental Health
William Ackerly, M.D.		Somerville Mental Health Center
John Collins, M.Ed.		Massachusetts Department of Mental Health
Diane Daugaweet		Mental Patients Liberation Front
Monica Dickens		The Samaritans
Jackson Dillon, M.D.		Greater Lynn Community Mental Health Center
Gilbert Foss		Mental Patients Liberation Front
Ann Fried, M.S.W.		Family Service Association of Greater Boston
Lois Gehrman, M.A.		Boston Children's Service Association
Joan Glasser		Mental Patients Liberation Front
Michael Gregory, M.R.P.		Health Planning Council for Greater Boston
Jon Gudeman, M.D.		Massachusetts Mental Health Center
Keri Holland, M.A.		Westfield Area Mental Health Program
Susan Holland, R.N.		Westfield Area Mental Health Program
Frances Lenehan, R.N., B.S.		Massachusetts Department of Mental Health
Phillip Lenz, B.A.		Massachusetts General Hospital
David Lescohier, M.S.W., M.P.H.		Massachusetts Department of Public Welfare
David Rioux, M.Ed.		Health Planning Council of Greater Boston
Gershen Rosenblum, Ph.D.		Massachusetts Department of Mental Health, Region V
Peter Ryder, M.D.		Massachusetts Mental Health Center

Committee on Inpatient Care

Conveners:	W. Robert Curtis, M.S.	Taunton Area Mental Health and Retardation Program
	Diane Daugaweet	Mental Patients Liberation Front
Patricia Andrade, R.N.		Corrigan Mental Health Center
Barbara Cole, M.Ed.		Executive Office of Human Services
Clifton Emery, Ed.D.		Taunton State Hospital
Anita Fine, R.N.		Corrigan Mental Health Center
Flora Gaudes, R.N.		Massachusetts Department of Mental Health
James Gorman, M.S.W.		Massachusetts Department of Mental Health

Janice Hinkle, M.A.	Taunton Area Mental Health and Retardation Program
John B. Hudson, Ph.D.	Northeastern Unversity (Formerly of Brockton Multi-Service Center)
James T. Kane, M.S.W.	Foxboro-Attleboro Area Mental Health Program
Robert M. Kaplan, M.D.	Massachusetts Department of Mental Health, Region VII
Dan Kesselbrenner	Mental Patients Liberation Front
Robert McGowan, M.A.	Taunton Area Mental Health Program
Norma O'Hearne, R.N.	Taunton Area Mental Health Program
Mary Raffini	Mental Patients Liberation Front; Elizabeth House
Barbara Wallen	Mental Patients Liberation Front
Ronald C. Werner, S.T.M.	Taunton Area Mental Health Program